# VOICE OF THE DIABETIC

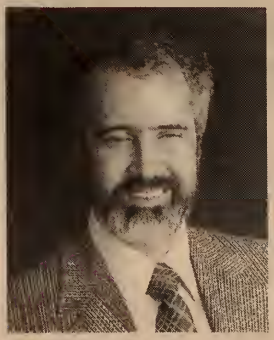
A SUPPORT AND INFORMATION NETWORK

*The Diabetics Division of the National Federation of the Blind*

**Volume 7, No. 4** **Fall Edition 1992** **Page 1**


## The *Voice* can be your voice absolutely free

**by Ed Bryant**



**Ed Bryant, editor of the *Voice of the Diabetic,* tells how the *Voice* is now offered free to interested persons.**

Emphasizing people and valuing individual involvement, the Diabetics Division of the National Federation of the Blind (NFB) is a grassroots support and information network. The NFB Division strives to show all diabetics that they have options despite complications which diabetes may have caused. The Division's outreach network provides help, understanding, and education.

The ***Voice of the Diabetic,*** a nationally distributed quarterly magazine published by the Diabetics Division, contains articles and information on all aspects of diabetes. Emphasizing self-management, alternative techniques and independence, the ***Voice*** is an upbeat, positive publication that reaches out to blind diabetics, those who are losing vision due to diabetes, the health profession community, and a wide range of other interested persons. Because all diabetics are at risk to develop complications, sighted diabetics also receive the ***Voice*** to learn how to circumvent possible diabetes ramifications.

The magazine exemplifies a contagious, positive philosophy. The current circulation of the seven-year-old publication exceeds 45,000 and is expected to grow rapidly. (Of 14 million Americans with diabetes, 15,000 will become blind this year.) The ***Voice*** is formatted in print and on one-half speed audio cassette.

The ***Voice of the Diabetic*** is now offered free to any interested person upon request. Each subscription costs $20 per year. To defray publication expenses, members are invited, and nonmembers are requested to cover the subscription cost. Although there is no membership fee, donations are gladly accepted and appreciated. Contributions are not only tax deductible, but are needed to help keep the ***Voice*** and the Diabetics Division moving forward to help people with all aspects of diabetes.

The NFB is a membership organization with more than 50,000 members. Membership in the Diabetics Division is membership in the NFB. Like a family, the NFB and its Diabetics Division provide members with priority services and unique benefits.

**Membership Benefits:**

- Members receive a continuing subscription to the ***Voice.***
- Members automatically have access to committees that are ready to help those with concerns about any aspect of diabetes. These committees cover such various topics as: Blindness/Visual Dysfunction, Amputation Prevention and Treatment, Heart Disease and Stroke, Insulin Pump, Legislative Issues, Pancreas Transplantation, Renal Failure/Dialysis and Kidney Transplantation, Resource Library, Resources: Aids and Appliances, and Male Impotence/Sexual Dysfunction.
- Members share a sense of family. Should concerns about diabetes arise, members can be put in touch with others having similar experiences. This

(Continued on page 13)


*Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!*

**News items, change of address notices and other magazine correspondence should be sent to:**

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# Independent travel tips for the blind

**Marc Maurer, president, National Federation of the Blind, has traveled independently as a blind person for many years.**

*From the Editor: The Diabetics Division of the National Federation of the Blind is a national support and information network that reaches out to any diabetic, especially men and women who are blind from diabetes. With an estimated 15,000 persons becoming blind each year from diabetes, there are thousands of newly blinded individuals needing to learn the alternative techniques that allow them to be involved in the mainstream.*

*I, for example, use a long white cane which allows me to travel independently wherever I wish to go. Our Diabetics Division, through the* ***Voice****, shows men and women how to self-manage their diabetes as blind persons. The National Federation of the Blind, with more than 50,000 members, knows that blindness is not synonymous with inability.*

You know a great deal about your own home — your house or apartment. You probably do not need any special tool or guide to get around there. You know the arrangement of the furniture, the shape and size of the rooms, the location of stair steps. But suppose you are suddenly blind — you can and will move about, though no doubt slowly and cautiously at first.

The basic rule is this: Do not let family members help you get around your own home, for you can do it yourself and it will help you learn to have confidence in yourself as a blind person. If you bump your shoulder on the edge of a doorway, you have done no damage to yourself or the doorway. If you bump your head on an open cupboard door, it may smart, but that is not serious either. The family pet will learn to get out of your way, but don't expect other people in the household to pick up everything just for your benefit. Some blind people are well-organized, just as some sighted people, while many blind people are fairly flexible about where things are. We have to learn to live with other people's habits, whether they leave the foot stool in the middle of the floor and the ashtrays exactly where they ought to be or not. Of course, it would not be safe in any situation to leave some things, such as an open can of paint or roller skates, in the middle of the floor. However, a blind person who is aware that such things are being used can generally deal with them and with the usual kinds of changes in a home quite adequately.

It is often assumed that a blind person cannot go anywhere by himself or herself. But no one walks with his or her eyes — it just doesn't make sense to think that the lack of eyesight prevents a person from moving around. It does make sense to find a method to get the information needed for safety in some other way, if an individual cannot see. This can be done.

There are several schools that train dogs to serve as guide dogs for the blind and train blind individuals to use these dogs. Guide dogs are trained to walk rapidly and it is recommended that those blind persons who use guide dogs use them regularly. Children are not able to travel with guide dogs because handling a large dog 24 hours a day — maintaining strict discipline for the dog — is a responsibility for which they are not prepared. Consequently, schools that train guide dogs and guide dog users do not accept individuals who are less than 14 or 16 years of age. This seems reasonable. A dog may seem exciting to a child, but it is important to maintain a minimum age requirement for a blind person to get a guide dog.

The white cane used by the blind as a tool to obtain information for travel purposes is a long white stick made of fiberglass or metal, with a metal tip at the bottom and a straight handle at the top. If an individual needs a cane for support, he or she will use this type of cane.

Either the long white cane or guide dog moving in front of a blind individual can be used to find out all one needs to know about sidewalks, streets, steps, obstacles, etcetera in his or her path. The blind person can get information about traffic movement by listening to it. A newly blind person must practice in order to learn to use the information obtained in this way as effectively as he or she used the information provided by eyesight in the past. It is a matter of developing a new skill — no more and no less.

A blind person who needs to learn to travel with a white cane should be able to get lessons from a teacher who works with blind children or from a rehabilitation agency. It is possible for a blind person to teach himself or herself a good bit about cane travel if it is necessary. Generally speaking, the more lessons one can get from a teacher, the better. There are specialists who teach cane travel, but most teachers of the blind can do it as needed, and if they can find the time. You must use the cane regularly in order to make it effective for you and to gain confidence in yourself as you use it. It is not unusual for a newly blinded person to be very frightened at the idea of walking alone on the street with only a white cane. With experience and practice, this fear will diminish and you will enjoy your new accomplishment. If you are walking with a friend or relative, you may wish to take the cane along also, so that you do not need to depend on the other person all the time you are away from home.

The cane should be long enough for its tip to rest on the ground a step and a half or two steps in front of you, with the handle centered slightly above your waist and close to the body. Grasp the handle in your palm, fingers up, and swing the cane left and right with wrist motion. Don't swing your arms, but use them to protect yourself from obstacles in front and on both sides, and to give information about steps and obstacles in time to make use of it.

Generally, it is desirable to tap the cane each time you take a step. When a step is taken with the right foot, the cane is tapped in front of the left shoulder. As the left foot moves forward, the cane moves to the right side of the body. This motion becomes automatic, and with practice you will react instantly and easily to information supplied by the cane.

White cane technique is simple and can be learned in a few minutes. However, it is very flexible, and the cane should be used differently in different situations. For example, in a crowd you will want to keep the cane close to your body to avoid tripping people ahead of you. This may mean that you will wish to take the arm of someone beside you or slow your speed, since you will have less time to react to information supplied by your cane. When climbing up steps, you will probably want to hold your cane in a straight-up-and-down position, letting the tip bump the step ahead of you. When the cane does not bump a step, you know you have reached the top of the flight of steps. Similarly, you will probably wish to let the tip of the cane touch each step ahead of you as you descend a flight of steps. You will find other situations in which you may wish to use the cane somewhat differently. The cane is meant to be a tool and you are the best person to know how to use it to get the information you need. However, it takes weeks or months of using the techniques for you truly to feel confidence in the skill.

A white cane can vary in length from less than 50" to more than 60" depending on the height of the individual using it and the speed at which he or she walks. Canes can be obtained from rehabilitation agencies or from the National Federation of the Blind. Although some white canes can be folded in fourths or even smaller, the rigid, fiberglass cane is most durable and is preferred by most blind people who are good travelers.

As the blind person practices, he or she will become aware of a great many other ways to get information while traveling. Of course, it is possible to get information about street signs and store fronts from other pedestrians. The odor of a bakery or a shoe store may be a good landmark. Blind people may take note of different types of landmarks from those commonly thought of by sighted people, but landmarks are helpful to all. A pole or a bench may indicate the location of a bus stop just as accurately as reading the sign. The sound of an escalator or a revolving door in a department store may be an excellent landmark.

If friends or family members are willing and available to help with transportation, it is efficient and pleasant to go places with them. Most people like to go some places alone. If public transportation (city buses, trains, or subway) is available, blind people can and should make use of it.

It may be frightening and frustrating at first to confront the hubbub and commotion in order to use city buses or subway, but thousands of blind people are doing this daily. Of course, it helps to have the moral support of an encouraging friend or teacher to take on independent travel as a blind person. The first few trips are the hardest. Truly learning to travel independently is an adventure or a series of adventures. If you are not looking for this kind of experience, you may be able to avoid it. However, independent travel is considered normal and necessary in our society, for the blind and sighted alike.

In the 1990's there is no reason for a blind person not to travel independently when he or she wishes or needs to do so. This is progress for the blind — important progress. Blind persons can go where they wish, alone or with a group. The techniques that exist have been developed to the point that anyone can learn them and use them. The training is increasingly available. You should take encouragement from the experience of the thousands of blind persons who have already learned to travel independently. You can, too, if you want to.

If you have further questions about independent travel or blindness, write to the: National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230.

# Arthritis and diabetes: a common association

by Thomas Pressly, M.D.

**Dr. Thomas Pressly pictured with his wife Tracy and their children Catherine and Thomas, reports on arthritis and how it is linked to diabetes.**

*From the Editor: Dr. Pressly is a practicing rheumatologist at Willis/Knighton Hospital and consultant in rheumatology at Shriners Hospital for Crippled Children in Shreveport, Louisiana. Diabetes is no stranger in the Pressly household. His wife, Tracy, has been an insulin-dependent diabetic for 28 years. Tracy contributed to the Fall 1988* ***Voice*** *with her article titled "My Children Are Healthy and I Have Diabetes." The Presslys are parents of two healthy children, Catherine, eight, and Thomas who is six years old.*

Arthritis and diabetes are both common conditions that affect many Americans. The musculoskeletal system can be affected in diabetes leading to conditions such as arthritis. For several reasons, diabetics should be aware of this association. In the presence of musculoskeletal complications, the knowledgeable diabetic can decrease pain, improve function and attempt to decrease the progressive severity of some forms of arthritis. Moreover, the diabetic should know that medications used for the treatment of arthritis can interfere with the treatment of diabetes. Modifications in medications sometimes must be made.

Arthritis is defined as inflammation of the joints. There are over 100 different types of arthritis. Almost forty million Americans have these disorders. Fourteen million Americans have diabetes mellitus. These common disorders can occur together. As stated previously, medications used in the treatment of one disorder can lead to the development of the other and/or can interfere with its treatment.

The most common types of arthritis are *osteoarthritis, rheumatoid arthritis, crystalline induced arthropathies* (e.g. gout), and *systemic lupus erythematosus. Osteoarthritis* is also known as degenerative joint disease or the "wear-and-tear form" of arthritis. Occurring commonly in families, it has recently been proven to be an inherited disorder. It commonly affects the hands, spine, hips, and knees. This form of arthritis is usually limited, affecting only the joints, and is more painful later in the day. It is thought to be caused by a defect in cartilage that results in bone destruction.

*Rheumatoid arthritis,* in comparison, can affect most of the joints of the body and is associated with prominent morning stiffness and swelling. It can involve internal organs such as the heart and lungs. Early diagnosis is important so that medications called remittive agents which can slow down the progression of the disorder can be administered prior to bone destruction.

*Crystalline induced arthropathies* are disorders such as *gout* and *pseudogout.* The joint most often involved in *gout* is the first metatarsal joint located at the base of the big toe. Many times people wake up with excruciating pain in this joint and then note total resolution of pain within three to four days. Bone destruction can occur with gout, but there are medications that can stop the process. Ninety percent of people with gout have one episode which never returns. The two most common factors that cause gout to flare are use of aspirin and alcohol. Gout also can be flared with the use of Thiazide diuretics (e.g. HCTZ, Dyazide, Maxide) which are commonly prescribed for high blood pressure. *Pseudogout* is a form of arthritis caused by the deposition of calcium pyrophospate crystals. An increased incidence occurs in people who have metabolic disorders such as diabetes mellitus. It commonly affects the knees and wrists. Like gout, it usually appears as a flare of severe pain, swelling, and redness in a joint. The condition spontaneously improves in a few days.

*Systemic lupus erythematosus* is a form of arthritis that can have marked internal organ involvement. Although any age group can be affected, it commonly occurs in women in their twenties. Early diagnosis and close follow-up are essential to treat organ involvement. *Lupus* is a disorder that can vary in severity. There are ten different sub-types of lupus which can vary from a syndrome of rashes and joint pain to life-threatening brain and kidney involvement. Certain medications — mainly heart medications such as procainimide and quinidine — can cause systemic lupus erythematosus. When the medications are stopped, systemic lupus erythematosus disappears.

Because *osteoarthritis, rheumatoid arthritis, gout,* and *lupus* are so common, many people with these disorders will also have diabetes mellitus. Diabetes also has specific musculoskeletal manifestations. Three categories of musculoskeletal disorders are caused by diabetes mellitus. Neuropathies (nerve involvement), arthropathies (disorders of the joints and connective tissues), and problems with skin, tendons, and muscles make up the three categories.

### Neuropathies

Several forms of *neuropathies* (nerve problems) can occur in diabetes. *Distal sensory* and *sensory motor disorders* involve nerves supplying feeling and muscular control over the hands and feet. Patients note a loss of sensation in a stocking/glove distribution. On examination decreased vibration and position sense, and decreased tendon reflexes are found. Neuropathies, inflammation of certain nerves of the body, can result in muscle weakness. The most commonly affected nerves are the cranial nerves to the face. This induces eye muscle weakness and weakness of the muscles of the face. *Diabetic amyotrophy* damages the nerves to the hip and leg muscles, leading to weakness of the extremities. Infrequently, it will involve the arms. This disorder frequently occurs in those with only mild diabetes and can spontaneously resolve. *Radiculopathy* is distress to major nerves coming out the back. This may be due to death of the nerve (infarction) and will result in electrical shooting sensations down the legs. This is frequently confused with symptoms of a herniated disc. When there is loss of position sense and loss of a sense of balance when walking, it is called *diabetic pseudotabes.* (This mimics a common finding in long-standing syphilis.) *Autonomic neuropathies* can result in decreased blood flow to the brain when standing *(orthostatic hypotension)* and can cause some people to pass out. *Impotence, abnormal sweating (dyshidrosis),* and *diarrhea* can also be due to autonomic neuropathies.

### Arthropathies

Several forms of *arthropathies* (disorders of the joints) occur in diabetes. *Osteolysis* is erosion of the bone commonly affecting the long bones of the feet and hands. This erosion can cause swelling of the fingers and toes, and weakening of the bones. *Osteoporosis* is the loss of bone substance. It occurs much more frequently in women than in men and there is an increased incidence in diabetics. Lifelong measures such as diet, regular exercise, and the use of estrogens at menopause can make a tremendous difference in prevention of this potentially devastating disorder.

*Charcot joints* are joints destroyed due to small fractures of the bone as a result of nerve damage to the joints. Diabetes can lead to a reduction of the blood flow in the small vessels to bones. Charcot joints are generally found in the ankles and feet. At advanced stages, the arch of the foot can collapse, which leads to marked difficulty in walking and a "rocker's sole" appearance on the bottom of the foot. With decreased sensation over the bottom of the feet, ulcerations and calluses can form. Therefore, attention to foot care is very important in diabetes.

Due to problems with the blood supply, nerve damage, and impairment of the immune system, infections can easily occur in diabetics. *Osteomyelitis* is infection of the bone and can easily be caused by objects such as pins which the patient with foot numbness steps on unknowingly. *Adhesive capsulitis* is the formation of scar tissue around the joint capsule. This will decrease the motion of a joint. The most frequently affected joints are the shoulders. In most cases, adhesive capsulitis can be treated with therapy and injections with good results. In a large study, 11 percent of diabetic patients had this disorder, and another study showed that 25 percent of patients with adhesive capsulitis were diabetics.

Connective tissue disorders can be specifically related to diabetes. *Hyperuricemia* (elevation of uric acid) and *gout* were initially thought to have an increased incidence with diabetes, but this has been refuted. In contrast, *diffuse idiopathic skeletal hyperostosis* has increased incidence with diabetes. This is deposition of bone substance over the spine and almost looks like wet sand flowing down a castle wall. It is usually asymptomatic despite having striking x-ray features. *Flexion contractures* occur much more commonly in diabetics. This condition may be due to decreased removal of skin collagen in diabetes compared to the increased synthesis of collagen that occurs in scleroderma. (Scleroderma is a systemic connective tissue disorder consisting of tight skin and various degrees of internal organ involvement. A more serious variant of scleroderma is called progressive systemic sclerosis. If the kidneys, lungs, or heart are involved, progressive systemic sclerosis can be rapidly fatal.) *Dupuytren's contractures* begin as nodules over the palms of the hands and then result in decreased movement in contracture of the fingers. They can also involve the feet. The "waxy-hand syndrome" *(cheiroarthropathy)* results in decreased motion of the joints, primarily in the fingers and toes. In this condition, feet and hands can develop tight skin that feels firm and waxy. A simple

(Continued on page 5

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## Arthritis and diabetes: a common association

(Continued from page 4)

screen test of this disorder, also known as limited joint mobility syndrome, is to have the patient place both hands on the table, palms down with the fingers fanned. The entire surface of the fingers makes contact in normal persons.

**Problems with skin, muscles and tendons**

According to one study performed by Rosenbloom, patients who had been diabetic an average of sixteen years with the presence of stiff joints also had an increased incidence of eye and kidney damage.

*Tenosynovitis* is the formation of nodules over the sheaths that go around the tendons in the fingers and toes. There is an increased incidence of nodule formation of the tendon sheaths in diabetics. This can result in what is known as a "trigger finger" or "catching of the digits" (in toes or fingers) on movement. Beginning in the elbow the tendon runs to the palm where it branches out into each finger ending at the tip. Each branch of the tendon is surrounded by a sheath which runs from the base to the tip of each finger. In *tenosynovitis* when the finger is bent, nodules (located in the palm of the hand) may be caught on the sheath causing the finger to be locked in place. Hence the term "trigger finger." The finger can be straightened by using the other hand to pull the finger forward; however, this is painful. The condition can be treated by finger exercises, steroid injection or by surgery.

Finally, circulated antibodies or immunoglobins directed toward different structures are increased in type-B insulin-resistant diabetes mellitus. This type of diabetes is due to antibodies directed against the insulin receptors, resulting in increased glucose. There has been an association of this disorder with *systemic lupus erythematosus, Sjogren's syndrome* (mainly manifested by dry mouth and dry eyes), and *progressive systemic sclerosis* (marked skin tightness and potentially devastating involvement of internal organs such as kidneys, lungs or heart). Progressive system sclerosis is a more serious, possibly fatal variant of scleroderma, which is mentioned above.

The treatment of arthritis includes rest, which is particularly important in rheumatoid arthritis and systemic lupus erythematosus. The use of hot and cold packs (thermotherapy) can be very helpful in decreasing pain and assisting with motion exercise. Protective splints can be very helpful with active arthritis.

Numerous medications are used to treat arthritis. Analgesics such as Tylenol decrease pain. Nonsteroidal, anti-inflammatory medications such as aspirin, Motrin, and Voltaren decrease swelling and pain. Disease-modifying agents, such as gold, can be very helpful in patients with rheumatoid arthritis. Such agents delay or prevent severe bone destruction and decrease pain and swelling. Urate-lowering agents are used to decrease the production of uric acid which leads to gout. Steroids are used for treatment of lupus, vasculitis (inflammation of the blood vessels), and in certain types of arthritis. Steroids should be carefully used, particularly with diabetes.

Some surgeries can prevent severe complications from occurring (e.g. tendon ruptures), but they are generally considered as a last resort.

It is important for patients with arthritis and diabetes to be aware of the interactions of medications. Low-dose aspirin has a mild glucose-lowering effect; larger doses of aspirin have a glucose-elevating effect. Oral hypoglycemics can raise blood levels of aspirin potentially leading to overdosage. Aspirin overdose can lead to complications such as ringing in the ears and stomach pain. Nonsteroidals interact with oral hypoglycemics by increasing their glucose-lowering effect. Steroids increase glucose and can disrupt control in people with diabetes. Finally, antigout medications can interact with oral hypoglycemics to lower the serum glucose leading to hypoglycemic reactions in some people. Arthritis medications can also be a problem with urine testing in diabetics. Aspirin and nonsteroidal anti-inflammatory medications can cause false-positive results for glucose and ketones.

This has been a very brief overview of interaction of diabetes and arthritis. If you do develop arthritis as a result of or simultaneously with diabetes, many things can be done to assist you, such as exercise programs, rest, and attention to foot care including proper shoes, and prompt treatment of infections of bones and related structures. Medications can be helpful in controlling symptoms and decreasing pain. Remember, some medications can interfere with treatment of diabetes. Although not highly recommended, surgery can be helpful in some instances. It is important that you have a detailed discussion with your doctor if you have both of these disorders because of the interactions between treatments. With 40 million Americans with arthritis and 14 million Americans with diabetes, I am sure some of you have both disorders.

For more information contact the American Diabetes Association, Arthritis Foundation, and your doctor. I will be more than happy to answer any questions if you would care to write me at 2751 Virginia, Ste. 2E, Shreveport, LA 71103.

# Florida researchers zero in on cause of diabetes

*from the University of Florida Health Science Center Communications*

**University of Florida pathologist Mark Atkinson, shown in his lab, has discovered an abnormal cellular response in the immune system that may help explain the cause of the most serious form of diabetes. (Photo by Russ Lante.)**

GAINESVILLE, Fla. — Florida scientists have discovered a critical glitch in the body's immune system that may help explain the origin of the most serious form of diabetes, according to a report in the British medical journal, *The Lancet*, appearing Saturday, Feb. 22.

Pathology researchers at the University of Florida College of Medicine say their finding may aid efforts to identify, early on, people who are at risk for insulin-dependent diabetes and lead to new therapies to prevent the disease.

In the *Lancet* report, UF researchers demonstrated, for the first time, how certain white blood cells vital to the body's defense against illness — call T-lymphocytes — multiply uncontrollably when they come in contact with a body enzyme called glutamate decarboxylase, or GAD.

The enzyme is a crucial component of insulin-producing beta cells in the pancreas. People require the insulin hormone to regulate how their body cells use and store sugar for energy. Insulin-dependent diabetes occurs when lymphocytes launch a self-directed, or "autoimmune," attack on the body's own insulin-producing cells.

"In our studies to date, the immune system's response to the GAD enzyme has been the first in a cascade of events leading to the eventual onset of diabetes symptoms," said UF immunologist Dr. Mark Atkinson, principal investigator of the study. "If we can prove the GAD-reactive lymphocytes are the initiating event in diabetes, we may be able to design ways to prevent diabetes."

More than a million Americans have insulin-dependent or Type 1 Diabetes, and require daily doses of insulin to survive. Type 1 diabetes, which usually strikes during childhood or adolescence, can lead to blindness, kidney failure, heart attacks and limb-endangering circulatory problems. The disease reduces the average life expectancy of diabetics by about one-third.

In the UF study, researchers isolated the lymphocytes from blood samples taken from 69 volunteers, and then exposed them to the GAD enzyme to see how the cells would respond.

The patients were divided into four groups: a control group of healthy non-diabetics; newly diagnosed diabetics; relatives of diabetics known to have special protein markers (antibodies) against the beta cells; and relatives of diabetics lacking the beta cell antibody markers.

Antibodies are special proteins of the attacking immune system specifically aimed at certain enzymes.

While all blood tests for the control group of 14 healthy individuals predictably registered no lymphocyte response to the GAD enzyme, 12 of the 18 people (67 percent) in the diabetic group displayed the telltale lymphocyte response.

Relatives of diabetics having the beta cell antibody marker for Type 1 diabetes also showed a high lymphocyte response (five of eight, or 63 percent) to GAD, compared to an 11 percent response rate (2 of 19) among relatives of diabetics with no antibody markers.

Antibodies against GAD have been used as a predictive marker for identifying likely diabetics since 1986, when Atkinson began using a diabetes screening test based on the presence of the antibodies in blood samples.

The GAD enzyme was known only as 64-K, named for its molecular mass of 64,000, until 1990 when researchers at the University of California at San Francisco chemically identified the protein as glutamate decarboxylase.

The GAD screening test reveals as early as seven years in advance which children or teen-agers will develop diabetes. Aided by the revealing antibody screening tests, UF physicians, directed by pathology chairman Dr. Noel Maclaren, are heading a multi-center trial using "immune-suppressant" drug therapy in an effort to prevent diabetes before symptoms appear.

While the strategy shows early promise, the treatment has a drawback in that it suppresses the entire immune system, making patients more susceptible to bacterial and viral infections.

The latest advance, though, may help scientists eliminate that complication, Atkinson said.

"If studies now underway show this lymphocyte response to be the initiating cause of insulin-dependent diabetes, we would then test ways of eliminating only the GAD-reactive lymphocytes from an individual," Atkinson said. "This might be a way to actually prevent diabetes without the side effects associated with immunosuppressive therapy."

# Passing on my experience, knowledge, and love

**by Marlene Curran**

*From the Editor: One evening my wife and I were attending an NFB dance during the 1991 national convention in New Orleans when Marlene Curran introduced herself and asked me to accompany her to meet her husband. I was delighted to meet him, and we had a good chat. Later, I was told that meeting me was a highlight for Pat because of my editorship of the* ***Voice.*** *Officers of the NFB are honored to meet and converse with our fellow blind brothers and sisters.*

Of all the complications my husband Pat and I have gone through over the last thirty years, the hardest to deal with was his blindness. While my husband was working for Commonwealth Edison, he became a good friend of Mary Burda and her husband Tony, who is blind. Tony, informed my husband about the Talking Books for the Blind and Physically Handicapped. (Regional Libraries for the Blind and Physically Handicapped provide free cassettes to any person who cannot see well enough to read print.) At this time my husband had about 5 percent vision in his left eye. Pat had undergone an unsuccessful vitrectomy in his right eye which left him blind in that eye. After the doctor filled out the form to certify his blindness, Pat got back into the world by reading these books. The tapes he enjoyed the most were the ***Voice of the Diabetic*** published by the Diabetics Division of the National Federation of the Blind (NFB). Those tapes were filled with information and inspiration. He felt as though he wasn't alone.

My husband had a bad case of pneumonia in 1989. After recovery, he discovered that he was totally blind. He had been holding onto that 5 percent sight for six years. He was devastated!

During the bout with pneumonia, his main worry had been about his third transplanted kidney. Thank God, the kidney survived. I tried to tell him to be thankful he still had the kidney; but nothing could compensate for the loss of his sight.

He became so depressed that I thought he would never come out of it. I didn't know how to help him. He was so upset that he couldn't putter in the garage, do his gardening, or walk the dog. He felt dependent on me. I know that this dependency was hurting him because he was a very independent person. I could see the hurt in his eyes. My heart was breaking to see him slipping away from me. He didn't want to talk about his blindness. For the first time, I felt totally unable to help him.

I told him to call Tony Burda for some advice or tips on how to cope with being blind. He had many conversations with Tony, and began to perk up. He looked up to Tony. He thought that because Tony could go to work every day by taking the El (mass rapid transit system-elevated trains), he could become productive and independent too. My husband would never have made it that far without the love and support of Tony.

Tony and Mary became our very good friends. We started to attend local chapter meetings of the National Federation of the Blind held at Tony and Mary's home. By being around other blind people, he started to learn that he, too, could be involved in the mainstream and enjoy life. Chapter members had a breakfast at Tony's house. The only two sighted people present were Mary and myself. On the way home after the meeting, my husband asked me all kinds of questions such as "How did the other people eat? How did they pour coffee without spilling it?" He gained confidence in himself and began to believe that he, too, could be independent like other NFB members. I will forever be grateful to Tony and Mary for all their encouragement and advice.

When the National Federation of the Blind convention was coming up, I suggested that we go to find out what we could learn. The convention was a very positive experience. If you haven't gone to a National Federation of the Blind convention, you must do so. I told Pat I needed to get some new clothes for the convention. He chuckled and said, "Why, who is going to see you?" He had a great sense of humor and never lost that.

When we arrived at the convention, we had to wait in the hotel lobby. I was amazed at how well blind people got around. I related everything I saw to Pat; he, himself, was in awe. There are many people who have a chip on

their shoulder because they feel they were dealt a bad hand; but not these NFB people.

After a few days at the convention, we felt like we were part of a big happy family. We were so comfortable. Each time we got onto an elevator, blind passengers put their hands out and introduced themselves saying, "Hi, I'm Sue from California," or "Are you here for the convention?" or, "Where are you from?" The biggest lift this convention gave my husband was discovering the independence of these blind people. My husband thought if they could get on a plane by themselves, or with a guide dog, and fly across the United States, he could do the same. Everyone was so gracious and friendly. Because of a bad leg, my husband was in a wheelchair at the time. Getting around was a little difficult. While shopping in the mall, I couldn't find a way of taking Pat to the other floors. I didn't know there were elevators. I passed two blind people, one of whom was also in a wheelchair. I asked her how she was able to get to the other floors. This blind person quickly reacted and said, "Follow me." She was so far ahead of me that I asked her to slow down. In nothing flat, we were in front of the elevators. I thanked her and she asked me if I needed any help. I told her no, but thanks and that I could see. She really got a big kick out of helping a sighted person. I admit I felt a little stupid and silly at the same time.

On another occasion when we were lost, a blind person helped us find our way to our room. When I asked how he determined the elevator location, our guide replied that he could hear the waterfall near the elevators. We learned to use our other senses to get around. We couldn't have learned these things at home. Only through this kind of experience was it possible for us to learn alternative techniques of blindness. Experience is a great teacher.

NFB conventions give courage and confidence needed to lead a normal life. We sat in on different meetings and learned more than we could have from books. Being in the company of 2,500 blind people makes it easier to learn because they are in the same boat. We all learned from each other. We were looking forward to the next convention in North Carolina; but my husband passed away November 29, 1991.

One doesn't have to be blind to be an NFB member. I'll be at the next convention and look forward to attending the yearly, three-hour seminar held by the Diabetics Division. I know from the experience of having lived with a diabetic who became blind that diabetics have many questions that aren't answered in the small amount of time allotted when they visit the doctor. Pat and I found answers to our questions at the Diabetics Division seminar.

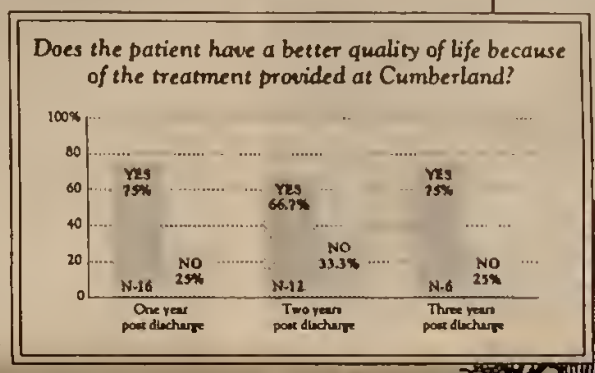
As of June, 1992 I've started a support group for Type I diabetics who are over 40 years old. My main goal is to help people cope with the complications they are facing. I hope to pass on my experience, knowledge, and love. Pat would want me to be involved this way.


ADOLESCENTS WITH DIABETES AND NONCOMPLIANT BEHAVIORS

## *Why Should You Refer Them to the Intensive Inpatient Program at Cumberland Hospital for Children and Adolescents?*

RESEARCH SUGGESTS that treatment in the Cumberland Hospital Diabetes Management Program benefits patients for a minimum of three years after discharge—that their diabetes is better controlled and that their social behavior is significantly improved. Treatment at Cumberland often breaks the cycle of frequent emergency room visits, hospitalizations and school absences.

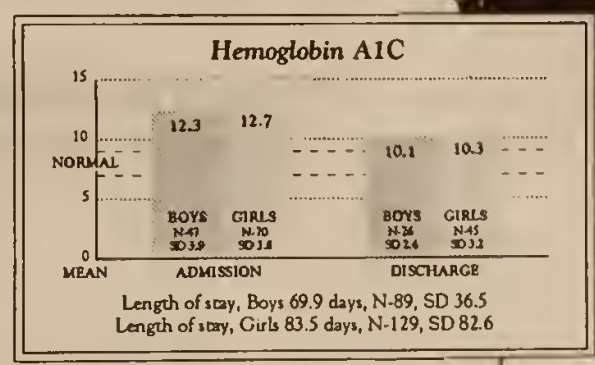
In a survey tabulated in December 1991, parents of patients treated by Cumberland Hospital in 1988, 75 percent said that their child had "a better quality of life because of the treatment provided three years previously by Cumberland Hospital."




The 1991 study continues with the work of a 1989 published report on 80 patients with diabetes treated at Cumberland in 1987 and 1988. In that study of patients one to three years post discharge from Cumberland, 73 percent said the patients are better and 23 percent indicated that they were the same.

CUMBERLAND'S PROGRAM specializes in the difficult-to-manage adolescent with diabetes. Almost all patients have failed in traditional programs—inpatient and outpatient—and have had life-threatening complications despite efforts to properly manage their diabetes.

The December 1991 outcome study examined 221 adolescents with diabetes admitted to the hospital from 1986 through July 1991. A sampling technique was used to target specific subgroups and to evaluate patient progress.




THE YOUNG PEOPLE in the 1991 study were diagnosed with diabetes in preadolescents (boys 8.0 mean years of age, N53, standard deviation 4.1, and girls 8.5 mean years of age, N-77, standard deviation 3.9). The mean age at admission was 15.4 years.

In a 1989 sample of 54 adolescents with diabetes treated at Cumberland between 1986 and 1988, it was found that they averaged 64 days in an acute care hospital during the 12 months prior to treatment at Cumberland and 32 days during the 12 months after treatment at Cumberland.

The 1991 study contacted parents of former patients one, two and three years post treatment at Cumberland to determine the long term benefits. These patients were treated at Cumberland in 1988, 1989 and 1990, and the results are far more favorable that the 1989 published study.

One year post discharge from Cumberland, the patients were hospitalized a mean of 10.8 days (N-15, standard deviation 20.3), two years post discharge and mean of 12.2 (N-13, standard deviation 13.8), and three years post discharge a mean of 7.3 (N-8, standard deviation 9.2).

SCHOOL ATTENDANCE is another good indicator of the success of an adolescent diabetes treatment program. In the 1989 study of 54 patients, patients missed an average of 40 days during the 12 months prior to treatment at Cumberland and 23 days during the 12 months after treatment.

The 1991 study of patients, one, two and three years post treatment was able to obtain limited information on school attendance. According to the study, patients during the 12 months after treatment missed an average of 8.87 days (N-8), and 14 days two years post treatment (N-5). School attendance data on only two patients treated three years post was obtained. They missed 5 and 10 days respectively, of school during their third year after treatment.

CONCLUSION

This study implies that patients benefit from treatment at Cumberland Hospital for a minimum of three years post discharge. This is demonstrated by a number of factors. For more detailed information about this study or any of Cumberland's Inpatient Programs, call the Information Office at 1-800-368-3472.

**Cumberland Hospital for Children and Adolescents**

New Kent, Virginia

# NFB Diabetics Division elects new president

by Ed Bryant

Donovan Cooper is the newly elected president of the Diabetics Division of the NFB.

On June 30, 1992 at the annual convention of the National Federation of the Blind in Charlotte, North Carolina, the yearly conference of our Diabetics Division took place. Karen Mayry served seven years as our division president and did an outstanding job. She will continue to serve on the division's Board of Directors for another year and will assist with the transition to the new administration. Besides overseeing the busy Diabetics Division, she served as president for the National Federation of the Blind of South Dakota. Karen is active and energetic, doing what she can to help blind persons through the NFB, the largest organization of blind people in existence. She decided to step down and not run for the 1992-1993 term because she felt new blood was needed to bring in new ideas and help the division grow to serve more diabetic men and women.

Donovan Cooper was nominated and unanimously elected to the position of president. He will have a hard time filling the shoes of Karen Mayry. However, Donovan has excellent credentials.

Karen Mayry is the outgoing president of the Diabetics Division of NFB.

Donovan has been a diabetic for more than forty years and has been blind for twenty-two years. He is a long-time member of the National Federation of the Blind, having held chapter office positions in Iowa and Nebraska before moving to California. He is currently president of the San Fernando Valley Chapter of the National Federation of the Blind of California and is Assistant Editor of ***The Blind Citizen,*** the newsletter of that state affiliate. He also serves as vice president of the NFB Public Employees Division.

Donovan began his training at the Iowa Commission for the Blind Orientation Center in 1971 where he had the opportunity to learn the skills of blindness and met many Federationists. In correspondence Donovan stated, "I was so excited when I got to Des Moines. I couldn't sleep for days. Back home, I had felt as if I was trapped in my parent's back yard by my blindness. That's not much of a life for a twenty-three-year-old man and certainly no future. In Des Moines, I found not only people who could teach me the skills of blindness, but I also found blind people who were doing good things with their lives. Like so many young people, I had always wanted to do good things with my life but I had few good role models and no productive direction or focus. The Federation leaders in Des Moines were great role models and their lives had such tremendous direction and focus. And, most importantly, they invited me to become a part of it. I did, and now extending those opportunities to others is a very big part of my life."

Following the completion of his Orientation Center training, Donovan enrolled at Drake University in Des Moines where he received a Masters Degree in Public Administration. For the last ten years he has worked as a Management Analyst for the United States Bankruptcy Court in Los Angeles.

Donovan has stated his intentions to help the division grow and prosper. He says, **"I am extremely pleased with the NFB Diabetics Division and the people who are involved. The members are open, easy to talk to, and eager to work. I will be happy to explore any and all initiatives with you. Please call or write me with any suggestions, comments, ideas or questions that you may have."**

Congratulations on your election, Donovan. We look forward to working with you.

## Board Members

*The Diabetics Division of the National Federation of the Blind.*

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# Still another "magic bullet" for the arsenal against organ rejection

## FK506: new anti-rejection medication

by Lisa Sulkoske, R.Ph.

Although the surgical techniques of organ transplantation have achieved significant progress, the remarkable success of the procedure is due in large part to the development of immunosuppressant drugs such as azathioprine, corticosteroids and cyclosporine. For this reason, the search for new immunosuppressants goes on.

One such new drug is FK506, an experimental immunosuppressant drug currently being studied for use on liver, kidney, heart and bone marrow transplant recipients. This new drug can reduce rejection, lessen the occurrence of infection, virtually eliminate hypertension and reduce the incidence of kidney failure more effectively than traditional medication therapies.

A product of the Fujisawa Pharmaceutical Co., Ltd., of Osaka, Japan, FK506 was originally isolated from a soil fungus sample in 1984. In 1989, clinical trials with transplant patients began at the University of Pittsburgh, where FK506 was initially given to patients who were taking cyclosporine and facing retransplantation because of ongoing rejection. The results were so encouraging for these "rescue" patients that FK506 was given to other patients as primary therapy or in combination with low-dose steroids.

This new immunosuppressant is now being tested at 30 transplant centers around the world. But the University of Pittsburgh, having used it on over 1,000 transplant recipients, has the largest chemical experience with the drug.

Research indicates FK506 is 100 times more potent than cyclosporine, which means it can be given in smaller doses to achieve the same effect. In addition, survival rate is increased with FK506. The drug affects special white blood cells called T-lymphocytes, which are part of the immune system and cause rejection of the organ. Rejection is the process of the activation and accumulation of T-cells into the organ. FK506, like cyclosporine, inhibits the secretion of certain proteins which are necessary for the T-cells to function.

As with any new medication, dosage can be difficult to determine. This is especially true for immunosuppressant drugs because with overdosage, there is risk of infection, drug toxicity and even development of tumors. With under-dosage, rejection can occur. Trials have indicated the oral dosage range for FK506 is .03 to .1 mg per dose.

Short-term side effects of FK506 include headache, nausea, vomiting and tingling sensations. Side effects tend to be less severe when FK506 is taken orally rather than intravenously. Unusual side effects include tremors, itching, insomnia, and abdominal and chest pain. There have also been rare cases where the drug acted as a poison against the nervous system creating seizures, confusion and coma. Despite these side effects, however, FK506 offers potential advantages in organ transplantation.

The ability of FK506 to prevent rejection and to treat advanced rejection, makes this an exciting and potentially revolutionary drug. At this time, however, it is still an experimental drug under investigation and until approved by the FDA, FK506 will not be available to the general population.

(Note: This article appeared in *For Patients Only,* May-June 1992, courtesy of Contemporary Dialysis Inc.)

# Ideas for increasing your chance of job success while still in college

by Lorraine Rovig

**Lorraine Rovig, Director of the Job Opportunities for the Blind program.**

*(Editor's Note:* This article appeared in the May 1992 issue of the ***Braille Monitor,*** published by the National Federation of the Blind. Barbara Pierce serves as the Associate Editor for the ***Monitor.***)

*From the Associate Editor: At this year's Mid-Winter Conference of the National Association of Blind Students held on Saturday, February 1, in conjunction with the annual Washington Seminar of the National Federation of the Blind, one of the many interesting presentations was a talk given by Lorraine Rovig, Director of the Job Opportunities for the Blind (JOB) program. Miss Rovig was addressing an audience chiefly composed of college students, so her remarks were aimed particularly at that group. They are, however, appropriate for job seekers of every age and circumstance. Here in large part is what she had to say:*

"Ideas for Increasing Your Chance of Job Success — While Still in College." That's easy! contacts, competence, variety, and jobs while still in school.

If you haven't started yet, despair not: just start now — this weekend.

**Contacts**

Good grades versus good contacts — how much time should you spend studying? For most professions, but not all, a B average is as good as an A. Try to maintain a B in most of your courses. And for most professions you need to average at least a B in a majority of the courses in your major; or you better change your major. If you can get a 4-point grade average while crafting a well-rounded, more sophisticated you, so much the better. If something's got to give, a well-rounded you and a 3-point will often serve you better than a 4-point with no frills added.

There are exceptions to the rule that a 3-point is good enough, by the way. For example, if you want to become a high-priced lawyer in a prestigious law firm or jump into a better-than-average position in management, you will need superior grades along with a well-rounded social life; but if you wish to become a research scientist, multitudes of interests not connected to science might work against your presenting the image of the focused, brilliant researcher.

As blind students you will need to spend time on activities your sighted peers never think about — recruiting and organizing readers, having textbook alternative media, getting an early start on term papers. You need time to learn to use the Braille 'n Speak, computer screen review programs, the slate and stylus, an optical character recognition reading system, and other devices to increase your efficiency and ability to work independently. How can you find the time?

1) Register for morning classes. Don't be like some I met during my college years. They acted as if any class that started before noon was a personal attack on their beauty sleep. Getting in the habit of a late start is something you can't afford. They couldn't either; but they didn't know it.

2) Don't allow yourself to get in the habit of an afternoon nap. I saw students do this when I lived in dormitories.

3) Read the book *How to Get Control of Your Time and Your Life* by Alan Lakin. NLS has it on disc — RD 8361. This is the best time management/life planning book I've found. And it's short — 160 pages in print.

4) Join the National Federation of the Blind. Check out your local chapter and your state affiliate. Try to go to at least one National Convention early in your college years. If you can't make it to the national convention, come to the NFB Washington Seminar or attend your own and nearby state conventions.

At these events make contact with blind people who are professionals in any field that interests you. Sit down with them and find out what they recommend for success. Talk to me here or call me on the JOB WATS line if you would like to be introduced to possible mentors. That number is 1-800-638-7518.

5) Look for mentors, blind or sighted, in your college community.

6) Look for ways to combine having fun with making contacts. Most people who find jobs do so through personal contacts. Joining college groups is a good way to increase your skill at personal interactions. And it's a very good investment of your time for the eventual job hunt.

7) Study ways to make friends. If you feel you have a hard time doing so, try this. Attend two or three meetings of some group that meets weekly, especially one that has lots of friendly camaraderie, and don't talk, just smile politely at your fellow students and offer the shortest possible friendly replies to direct questions. While you're being a quiet bump on a log, analyze the conversations and interactions you observe. Then, try to use your observations and the resulting understanding of the group's subculture to become a part of the group.

Do not, however, allow yourself to remain a bump on a log. If one group doesn't fit you, try another. These years at college are an ideal opportunity to try out several new you's or just put some polish on the standard model.

8) Join something formal. If I were you, I'd look for a minimum of two groups per semester that will do two or more of the following:

- Train you in a new skill (canoeing, debating, singing German beer hall songs, whatever);
- Increase your ability in a skill already learned;
- Give you a brag on your resume;
- Introduce you to fellow students in a cooperative environment;
- Afford you the chance, sooner or later, to become an officer;
- Introduce you to professors, one-on-one;
- Provide entreè to people at work in the profession that interests you;
- Introduce you to possible future employers in a way that will give them a chance to get to know you personally;
- And this is important, too — join groups that help you enjoy life at college. We do better what we enjoy doing.

During the first weeks at college go through every bulletin board at the student union and at your dorm. Read the local student newspaper, the local town paper, and any handouts from the student union offices. Check for the location of bulletin boards in the office suite of the building that houses the professors in your major and minor areas of study. Check bulletin boards in the university library and, if you use it, any sub-library, such as a law library or other specialized materials center. The object is to discover what local groups are available to you.

Consider the comparative merits of local student groups — an honor society, Hoofer Outing Club, the Apple Biters computer users group, the Society for Creative Anachronisms, the Natural Belly Food Co-Op, the No Nukes Is Good Nukes roundtable, Sierra Club, Friends of the Library, the university chess club, the community hot-line for people at risk, campus political groups, and so on.

Check out available student activities — student government, the special services office advisory board, the debate society, the Writers Association, the student newspaper, the school radio station, sororities, fraternities, the yearbook staff.

Consider ways in which you could take an active role in yearly special events — such as annual parades, local big — deal football games, Drake Relays Week, Spring Fling.

9) Participate in Something. Some of the groups you join won't be formally organized — should never show up on your resume — but offer ideas and training you won't get in your room or while studying in the library.

For instance, back at UW-Whitewater I found myself a regular member of the crowd that showed up faithfully once a week in a student union TV lounge. Laughing along with the regulars watching "Batman and Robin" taught me that my sense of humor was shared by other people. What a relief! That lounge was also a free education in current dating customs of American college students while in public view. (You never know what data will come in handy.)

During your years at college try to join groups that will demonstrate to future employers that you get along well with others, have some mental or athletic ability (or both), and are interested in more than — as I see on too many resumes — "Other Activities: Reading and Music." If your only "Other Activities" are "Reading and Music" or "Poetry," for heaven's sake, don't tell that to a prospective employer!

Another thing, even if you plan to take a job working for the particular religious denomination you belong to, you are better off if you do not narrow your choices to only clubs or offshoots of that faith.

Furthermore, for the same reason, don't join only those groups that are associated with blindness or with handicaps. Even if you plan to get a job in a disability-connected field, you will be more valuable to an employer and to those you plan to serve or help, if you stand out as one who moves easily between groups of handicapped people and the broader society.

10) Sometime during your college years, become an officer of something. Something is better than nothing here. Being an officer of anything points to leadership qualities. Some club positions and some groups, of course, give you better brag material for certain professions than others.

If you plan to succeed in business, having been elected treasurer of the judo club is useful; having worked on a successful fund-raising campaign for a campus literacy center or a P.R. campaign for the local Spring Fling might be better.

**Competence**

On Monday I spoke to President Maurer about ideas for this presentation. He said he believes the most important thing for students in college is to learn basic competence in something. I said, I remember some guys at

(Continued on page 10)

# Increasing your chances of job success

(Continued from page 9)

Whitewater who seemed to major in playing poker in the union. Mr. Maurer remarked, if you can become competent at poker, you can make a living at that.

He said, "Learn to be a competent traveller, learn to write. No matter what you study, those two skills will help you get a good job. Most people can't write. Fortunately," he said, "the more you do it, the better you will get."

I agree. I'd add to that — more important than any one grade in any one class is competence in your use of the English language. Make no excuses for yourself. If you make mistakes in grammar, in use of commas, in spelling, in word choice or pronunciation — go thou and learn to do it right. Most schools these days have a remedial language lab. However they disguise its name, find it and take advantage of its services. If it is there, but fails to teach well, look around for a better option. If you must, hire a retired English teacher as tutor.

Here's one more thing that could make more difference in your ability to get a good job than a 4-point GPA. Using non-standard pronunciation of words, for any reason, is not expected from an educated person. Users of non-standard English must upgrade their speech if they wish to succeed. If you say, "Ax me another question" or "Me and him are gonna study in the libary," you will have to change if you want to make an impression as a college-educated professional, worth a professional's salary.

I've read interviews with actors from places like Brooklyn or Texas who say they taught themselves to speak standard English without their down-home accents in order to get more jobs. If they can, you can. The bottom line is that a little accent can be an asset in a professional job, but non-standard English will be a detriment your whole life long. And unless you wish to stay in the environment that taught it to you, a heavy accent of any kind, which makes your conversation difficult for non-compadres to understand, will be a detriment. Write like a professional; sound like a professional; you'll have a better chance of becoming one.

A word about increasing your competence as a traveller. While you are at this conference, observe the travel skill of those around you. Is someone traveling better than you can? Analyze his or her technique; talk to that person; learn from the best.

### Variety

Let me ask you a question: If you were the boss looking at the following two resumes, whom would you rather hire as a reporter? Whom would you rather hire as a buyer for your towel factory? Whom would you invite to interview for an Independent Living Specialist position in your rehabilitation agency? Let us presume that both resumes show the basic degree required for your particular business.

The first resume shows a 4.0 GPA with honors; a one-year position on the Mayor's advisory board for People with Disabilities; seven years membership in the St. Paul Evangelical Mixed Choir; and "Other Activities: Reading and Music."

The second resume shows a 3.1 GPA; a reading knowledge of French and German; two years as a reporter for the college paper, one year as editor; one year on a swim team; three years in a folk dance club; membership and an elected office in the National Federation of the Blind, which provided opportunities to plan a fundraising campaign, make speeches to groups as large as 300 people, and participate in legislative activity on both state and national levels; membership in Pets on Wheels; an award for leadership of the dorm committee designing and building the best float in the 1990 Pufferbilly Days Parade; and six different part-time jobs — all at low levels but two using computer skills. Under "Hobbies" is listed: "Visiting Civil War museums and battlefields" and "Collecting Elvis memorabilia."

If you were the employer hiring the reporter or the buyer or the Independent Living Skills teacher, which resume best tells you the applicant is likely to have the ability to learn the job you wish to fill and gets along well with all sorts of people?

I suggest that, over the course of your attendance at an institution of higher learning, you join and participate in at least one group in each of the following categories: professional or pre-professional organizations; groups associated with the outdoors or physical activity; groups involved with mental activity; clubs that give you a chance for leadership; and, of course, the National Federation of the Blind. Depending on your field, I'd suggest a group involved with theater, art, music, or great literature. Some groups will combine two or more of these attributes, so that is a bedrock minimum of three groups over four or five years of college. For most resumes, more would be better.

### Jobs While Still in School

It is very, very, very, very important that you get and succeed in some job or jobs while you are still in college. The more job experience you can obtain before you graduate, the easier it will be to convince first yourself and then the interviewer that you can competently handle whatever comes. You say you know how to study, but you don't know how to handle a job? Start talking! — especially with blind mentors. I refer you again to item one: contacts.

You won't add to your resume by going home to your parents' rural farm or not-on-the-busline aunt's home in the suburbs and letting yourself vegetate over the summer. If you are stuck at home somewhere without transportation, consider ways to turn that possible lemon into lemonade. Can you write? Will it sell? Is there a skill you need to learn?

Look for internships in your field. Look for work in your major departmental office and try to parlay that into contacts that lead to internships. Train some or all of your readers to tell you about notices of jobs and internships in your field that are posted on departmental bulletin boards or in school papers. Some such jobs are likely to be found in the magazines written for your specialty. Whether you are planning to become a systems analyst or a water hydrologist, there are magazines dedicated to your field. Build in reader time on a regular basis to skim these professional journals.

Find the alumni or career office in your college. Do these folks have a list of alumni who are available for informational interviews? If you've never done one before, can they advise you how best to proceed? (If not, ask JOB.) What other services do they offer? Does your college subscribe to a computer bulletin board service that features job openings?

Have you ever asked a friendly professor in your specialty to introduce you to visiting speakers or to his or her acquaintances at work in your field? Have you asked directly for help making useful contacts at professional meetings? Have you studied ways to make the rounds, to locate and talk to the movers and shakers in group meetings, business breakfasts, seminars, job fairs? JOB can give you a list of ideas a blind person can use to make contacts at such gatherings.

Something is better than nothing. One job is okay, more is better. Look for jobs that will demonstrate skill with people, skill in organizing, and skill in supervising and flexibility. (Of course, any blind student using readers and drivers, whether paid or volunteer, can demonstrate all that.) Here are some specific places to get job leads:

1) Ask your fellow students at this national conference these next two days how they found their jobs. Ask the blind adults you sit next to or stand beside in line what jobs they have found. If you discover a good contact, ask that person or persons to join you for breakfast or dinner here. Grill them! Remember to take down their home addresses and phone numbers.

2) Sign up for the free ***JOB Recorded Bulletin,*** or if you can't handle one more taped magazine coming to your address right now, go borrow an occasional copy from the state library for the blind. Eight times a year that bulletin is as full of ideas as we can stuff it.

3) Talk with friends or friendly acquaintances you know in these clubs and groups you've joined. Let them know you are looking.

4) Talk with your departmental professors. What is available right there on campus or in the community?

5) Talk with the university office in charge of arranging work-study assignments.

6) Have a folder or a drawer just for job leads, job contacts, and other information to help you find jobs at college and between semesters.

7) Ask your relatives for help. Has anybody noticed any job openings? Whom does your father know? Your mother? Your uncles? Your long-time neighbor?

8) If you want a summer job as an aide in a Congressional office in Washington or in a state district office, have you talked to Dan Frye or to Judy Sanders?

9) Would you benefit from a part-time job in a federal government lab or agency? The government has some special opportunities for college students as part of its effort to hire them before they get spoiled by working for commercial entities. Have you talked to Jim Willows about working at Livermore Labs in California, to Karen Edwards or Dr. John Rowley about the Los Alamos National Labs in New Mexico? Have you talked to John Halverson, President of the Public Employees Division of the NFB?

10) Have you explored the metro area your college is in? What would give you an edge in job hunting there?

Contacts, Competence, Variety, and Jobs While Still in School — do you want more ideas? Register with JOB (Job Opportunities for the Blind). Read the free ***JOB Recorded Bulletin.*** This program was designed by the blind for the blind. Our number again is (800) 638-7518. Read the ***Braille Monitor*** on cassette, on disk, in print, or in Braille. If you are diabetic, read the ***Voice of the Diabetic.*** It is available on cassette or in print.

Mr. Maurer said one more thing I want to pass on to you: "Get used to working hard, and get used to succeeding in what you do." Thank you.

If you or a friend would like to remember the Diabetics Division of the National Federation of the Blind in your will, you can do so by employing the following language:

"I give, devise, and bequeath unto Diabetics Division of the National Federation of the Blind, 1800 Johnson Street, Baltimore, Maryland 21230, a District of Columbia nonprofit corporation, the sum of $_____" or "_____ percent of my net estate" or "the following stocks and bonds: _____") to be used for its worthy purposes on behalf of blind persons."

# Diabetic retinopathy

## Diabetes can affect sight

Diabetes mellitus is a condition which impairs the body's ability to use and store sugar. Elevated blood sugar levels, excessive thirst with an increase in urine excretion, and changes in the body's blood vessels are all characteristic of the disease. Diabetes may cause serious changes in the eyes as well. Conditions such as cataracts, glaucoma, occasional blurring and, most importantly, changes in the blood vessels at the back of the eye all may affect sight.

**What Is Diabetic Retinopathy?**

Diabetic retinopathy is a complication of diabetes that affects the eyes. It is caused by the deterioration of the blood vessels nourishing the retina at the back of the eye. These weakened blood vessels may leak fluid or blood, develop fragile brush-like branches, and become enlarged in certain places.

The retina is the part of the eye where light filtering through the lens is focused. The focused light or images are then carried to the brain by the optic nerve. When leaking blood or fluid damages or scars the retina, the image sent to the brain becomes blurred.

The risk of developing diabetic retinopathy is high for people who have had diabetes for a long time. About 60% of those having diabetes for 15 years or more have some blood vessel damage in their eyes. When diabetes develops in childhood or teenage years, it is known as juvenile diabetes. Juvenile diabetics are particularly likely to develop diabetic retinopathy at an early age. Only a small percentage of those developing retinopathy, however, have serious problems with vision, and an even smaller percentage ever become blind. In spite of this, diabetic retinopathy is the leading cause of new blindness among adults in the United States, and people with diabetes are said to be 25 times more prone to blindness than the general population.

There are two forms of diabetic retinopathy. In one form, *background retinopathy,* blood vessels within the retina change. Some vessels decrease in size and others enlarge and form balloon-like sacs which obstruct the flow of blood through the vessels. These vessels leak and hemorrhage causing swelling of the retina or forming deposits called exudates.

Background retinopathy is considered an early stage of diabetic retinopathy. Fortunately, sight is usually not seriously affected and in 80% of the cases the condition does not progress. However, in some cases, the leaking fluid collects in the macula, the center portion of the retina which is responsible for central vision. Straight-ahead images, reading and close work may then become blurred, and loss of central vision can result in legal blindness. Background retinopathy is a warning sign and can progress to more serious, sight-endangering stages.

The second form is *proliferative retinopathy.* This begins in the same manner as background retinopathy with the addition of new blood vessel growth on the surface of the retina or the optic nerve. These fragile new blood vessels may rupture and bleed into the vitreous, the clear gel-like substance that fills the center of the eye. If the leaking blood clouds the normally clear vitreous, light passing from the lens through the vitreous to the retina is blocked and images are distorted. Additionally, scar tissue forming from the mass of ruptured blood vessels in the vitreous may tighten and pull on the retina, tugging it away and detaching it from the back of the eye. Blood vessels may even grow on the iris and cause a form of glaucoma. Severe loss of sight and even blindness may result from these conditions.

**Cause and Symptoms**

The cause of diabetic retinopathy is not completely understood; however, it is known that diabetes weakens small blood vessels in various areas of the body. Pregnancy and high blood pressure may worsen this condition in people with diabetes.

Though gradual blurring of vision may occur, sight is usually unaffected by background retinopathy, and changes in the eye can go unnoticed unless detected by a medical eye examination.

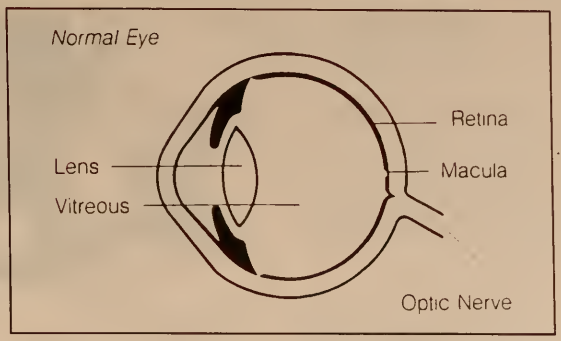
When bleeding occurs in proliferative retinopathy, the patient has hazy or complete loss of sight. Though there is no symptom of pain, this severe form of diabetic retinopathy requires immediate medical attention.

**Detection and Diagnosis**

A comprehensive medical eye examination by an ophthalmologist is the best protection against the progression of diabetic retinopathy. People with diabetes should be aware of the risks of developing sight disturbances and should have their eyes examined regularly. (People who don't have diabetes should also have their eyes examined periodically because these examinations help to detect the presence of diabetes and other diseases.)

To detect diabetic retinopathy, the ophthalmologist painlessly examines the interior of the eye using an instrument called an ophthalmoscope. The interior of the eye may also be photographed to provide further information.

If diabetic retinopathy is noted, a second method of examination may be used by the ophthalmologist to see which blood vessels are bleeding or leaking fluid. First a fluorescent dye is injected into the arm. The dye travels through the bloodstream and passes into the blood vessels of the retina. Photographs are taken rapidly of the dye as it leaks through the retina's blood vessels. This technique, called *fluorescein angiography,* is sometimes used by ophthalmologists to determine if further treatment is necessary.




**Treatment**

When diabetic retinopathy is diagnosed, the ophthalmologist considers the patient's age, history, lifestyle, and the degree of damage to the retina, before deciding whether treatment or monitoring of the disease is most appropriate. In many cases treatment is not needed; in others, treatment is recommended to halt the damage of diabetic retinopathy and sometimes to improve sight.

Probably the most significant treatment is the use of ophthalmic laser surgery to seal or *photocoagulate* the leaking blood vessels. This procedure *focuses a powerful beam of laser light* energy onto the damaged retina. Small bursts of the laser's intense heat stop the bleeding by sealing leaking vessels and forming tiny scars inside the eye. These scars reduce abnormal blood vessel growth and help bond the retina to the back of the eye. This treatment does not require any incision and may be performed in the ophthalmologist's office. If diabetic retinopathy is detected early, photocoagulation by ophthalmic laser surgery may stop continued damage. Even in advanced stages of the disease, it can reduce the chance of severe vision loss.

However, photocoagulation cannot be used in all patients. Depending on the location and extent of diabetic retinopathy, and if the vitreous is too clouded with blood, another treatment must be used. In this surgical procedure, called a *vitrectomy,* the blood-filled vitreous is removed from the eye and replaced with a clear, artificial solution. About 70% of vitrectomy patients notice an improvement in sight. The ophthalmologist may recommend a vitrectomy soon after the vitreous becomes clouded by blood, or wait up to a year to see if the eye clears up itself naturally. The timing for each patient depends on the extent of damage to the eye and to the condition of the other eye. If, however, diabetic retinopathy causes the retina to detach from the back of the eye, severe sight loss or blindness can result unless surgery is performed immediately to reattach the retina.

Successful treatment of diabetic retinopathy not only depends on early detection with monitoring and treatment by an ophthalmologist, but also on the patient's attitude and self-care. All medications should be taken, and diet to control diabetes should be followed as directed. Although physical activity presents few problems with background retinopathy, it can increase bleeding in proliferative retinopathy. Exercise for patients with proliferative retinopathy should be moderate, and straining or leaning over with the head down should be avoided.

**Who Can Treat Diabetic Retinopathy?**

Only an ophthalmologist can treat diabetic retinopathy. An ophthalmologist *is the medical doctor (MD or osteopath)* who is educated, trained, and licensed to provide total care of the eyes. This care includes performing comprehensive eye examinations, prescribing corrective lenses, diagnosing diseases and disorders of the eye, and using the appropriate medical and surgical procedures necessary for their treatment. Some ophthalmologists specialize in the treatment of retinal diseases such as diabetic retinopathy.

**Loss of Vision Is Largely Preventable**

Early detection of diabetic retinopathy is the best protection against sight loss. Even when symptoms are not noticed, people with diabetes should schedule examinations by an ophthalmologist at least once a year. Medical eye examinations should be scheduled more frequently after diabetic retinopathy is diagnosed. In most cases, with careful monitoring, the ophthalmologist can begin treatment before sight is affected.

If you have additional questions or would like further information, contact your ophthalmologist.

The American Academy of Ophthalmology is an organization of 16,000 ophthalmologists dedicated to preserving eye health and sight. Remember, an ophthalmologist provides total eye care: medical, surgical and optical.

(Note: This information appeared in *Diabetic Retinopathy: Diabetes Can Affect Sight,* courtesy of the American Academy of Ophthalmology.)

# Feet treats
## Buying a shoe that fits right

by Anthony L. Pojman, DPM

"Doctor, my feet hurt."

This complaint is heard every day by foot specialists (podiatrists). The majority of the time, the individual with sore feet is not suffering from some traumatic foot condition but is simply the victim of his or her own footwear.

**The Size of the Problem**

According to some surveys, approximately 88 percent of women wear shoes that are at least one size too small. This obviously can create foot problems. For both women and men, chronic foot pain, corns, calluses and pinched nerves may be a direct result of ill-fitting shoes. Conditions such as bunions and hammertoes are aggravated, but not caused by, poor fitting shoes.

The length of the shoe is not the true culprit in many foot conditions. The blame lies in the shoe's toe box. This is especially true with high heels or other fashionable shoes. The toe box is usually very narrow and puts undue pressure on the toes and structures in the ball of the foot. The toe box should be wide and shaped like your foot.

A good way to make sure that your shoe is wide enough in the toe box is to trace an outline of your foot and your shoe. By comparing the two outlines, you can easily determine if the shoe is wide enough for your foot. You may be quite surprised at how much your foot can overlap the shoe.

Aside from a tracing of your foot and the shoe, the best defense against buying ill-fitting shoes is to have your foot measured. I often ask patients when they last had their foot measured. Often they admit it was when they were in their teens and their parents took them shopping. Do not rely solely on checking the shoe against the big toe. The second toe may actually be the longer toe. The shoe should be about one-half inch longer than your longest toe.

One question commonly asked by adults is whether or not their feet are still growing. This would seem to go along with the complaint that their shoe size has increased one size when buying shoes.

The foot is essentially complete in growth at age 16. As we age, the strutures that support the arch may relax or loosen and then during weight bearing, the foot may flatten and the arch fall. This flattening may cause the foot to both spread out to the side

and lengthen. This can cause an increase by one shoe size in both length and width. Aging is not the only culprit in this process. Pregnancy may also be responsible for flattened arches. This is due to a combination of excess weight and hormonal changes causing ligaments in the arch to relax.

Time of day plays an important part in shopping for shoes. The best time of day to buy shoes is at the end of the day. Your feet will be the most swollen and usually a little flattened. If the shoe feels great at this time, chances are it will work well for you.

**Shoes Need Good Makers**

Once the correct size is determined, choosing what type of shoe to buy is the next task. The upper should be made of soft leather that will mold to your foot and allow your foot to breathe. The inner lining and insole of the shoe should be softer and offer some kind ot arch support.

The back of the heel or "heel counter" is a very important part of the shoe. This should be firm and hold its shape if you place your thumb and index finger on the rear of the shoe and attempt to squeeze your fingers together. To better understand this, view the foot as a bag of bones. If the heel bone is cradled and supported well in the shoe, the rest of the bones will be stable, whereas if the heel is moving around, the remaining bones follow and you end up with an unstable foot.

One final component you should look for in a shoe is the outer sole. The outer sole should be made of a rigid material. This encourages a rocking motion with walking and helps prevent extreme pressure on the ball of your foot.

Do not wear new shoes for more than an hour at a time for the first several days. After wearing them, take them off and inspect your feet for any reddened areas — a sign of undue pressure. These pressure spots on the shoe can then be stretched at any shoe repair store.

**Is there a "10" Shoe?**

Many patients ask me what is the best shoe on the market.

The shoes I recommend are actually based on feedback from patients. Shoes that have received good ratings include Rockport™ shoes and Easy Spirit™ by U.S. Shoes. The walking shoes marketed by both these companies have all the components discussed in this article. In buying shoes you will be relatively safe in staying with brand names. Brand name companies have usually researched and tested their products. Be leery of cheap shoes sold in discount stores. Buying a good pair of shoes will save you money in the long run.

Protect and house your precious feet. You need them to carry you through a lifetime.

(Note: This article appeared in *Living Well With Diabetes,* Winter 1992, courtesy of International Diabetes Center.)

# Ask the doctor

by Floyd Brown, D.O.

***My mother was recently diagnosed with diabetes. Please tell me what causes it.***

The body needs sugar to maintain good health. Sugar circulates through the bloodstream to be used by the cells and organs. Insulin, a hormone made in the pancreas, regulates the body's use of sugar by controlling the amount the cells absorb from the bloodstream. Without sugar, the body couldn't function. For people with diabetes, sugar can be deadly. Diabetes occurs when the body doesn't make enough insulin or the blood cells aren't able to use it properly. When this happens, sugar can build up in the bloodstream and cause problems throughout the body.

***I'm worried about what diabetes will do to my mother. Tell me about its effects.***

If diabetes is not treated properly, it can add to a person's chances of developing hardening of the arteries. It can also increase the risk of heart disease, kidney failure and stroke. Loss of circulation in the extremities, which can lead to amputation and vision loss can also be complications.

***What are the symptoms of diabetes?***

Warning signals include dehydration, frequent urination, weight loss and weakness. Other signs are increased thirst and appetite and blurred vision. Often there are no symptoms early in the disease. This frequently causes a delay in proper diagnosis and treatment.

Any of the symptoms mentioned above, or a combination of them, especially in someone with a family history of diabetes, is reason for an immediate visit to the doctor.

***How can I help my mother cope with her diabetes?***

Controlling and living with her diabetes will take commitment and dedication from not only your mother, but you and the rest of the family. The good news is that the complications of diabetes can be minimized with a balanced diet, exercise and the use of oral medications or insulin to make up for her body's deficiency.

(Note: This column appeared in the July 30, 1991 issue of the *Lincoln County Journal,* Troy, Missouri.)

# A diabetic diary

by Gerald Scott

*From the Editor: Gerald Scott is eighty-six years young and continuously educates himself about diabetes. During a conversation, he related that he was a little reluctant in writing parts of his article because of their sensitive nature. Gerald monitors his diabetes and plans to be around for a long time.*

*I am glad that he decided to share his experiences because I know other* ***Voice*** *readers have had the same side effects. Many of the more than fourteen million Americans with diabetes have experienced ramifications of the disease. Diabetics often find it helpful to hear from someone who has "been down the same road."*

It has been about 11 years since I was diagnosed as a diabetic. Since that time, my efforts to control the disease have included dieting, exercising, drug treatment, and insulin injections. I have had several symptoms including low blood sugar attacks, lame legs, and digestive problems. For a while, I wondered when symptoms of nerve deterioration would show up. Such problems are caused when damaged nerves cannot properly control parts of the body.

The first sign to show up was difficulty in swallowing food. When eating in public with friends, I could not swallow the second bite of food. After throwing up in the restroom and waiting about 10 minutes, I was able to regain control. Looking back, I believe the nerves controlling the esophagus were not working properly.

Next, I noticed my right leg often became sore when walking. To combat this, I sat down and rested for a few minutes until I could walk again. A drug called Trental helped control this. I now walk two miles a day with no pain.

For the last few years I've had trouble with waste elimination. I attribute this to the abnormal closing of the anus after a bowel movement, which causes me to take more time than usual to complete. In addition to being annoying, it is embarrassing to discuss this. It is an item lots of people neglect to discuss with their doctors.

Along this same line of thought, I am also impotent. All of the instincts and desires are there, but no action. Of course, the fact that I am 86 years old may contribute to my condition.

About three years ago I was talking with a friend as I relaxed in my recliner, when someone passed by my window. For some unknown reason, I stood up very quickly and took three long strides to the window. I collapsed and "passed out" for about a minute. My friend pulled me to my feet, and I was fairly well under control in five minutes. I was so shook up that I went to the emergency room at the local hospital, where an E.K.G. was done. Being declared normal, I was sent home with the advice that I should not get up so fast. I didn't know how right the advice was until I read an article in *Diabetes in the News* that defined this problem as diabetic neuropathy. This information brought all of my experiences and thinking together.

When my doctor gave me a treadmill test, I lasted about four minutes. Most people last about 17 or more minutes. After four minutes, I could not stand alone or speak coherently.

I was sent to the hospital for testing and was told that I might have to have a "balloon" treatment for restricted blood circulation. I was given many tests which revealed that I was anemic; that is, my blood iron was too low.

Apparently doctors didn't realize that my chest numbness was caused by slow nerve reaction and lack of pain due to neuropathy. I recently read an article discussing this. It stated that due to lack of nerve control, the heart does not speed up properly to adjust for the exertion level. At its worst level, this is known as a "silent heart attack" because the imperfect nerves do not register pain.

In connection to these, I have a sleeping problem. I get up to use the toilet in the middle of the night, having slept well until then. After returning to bed, I cannot rest. I used to think it was caused by an overactive mind, but now I think that it is caused by unregulated heart action. I believe this is caused by the fast, irregular heartbeat which prevents relaxation. The cure for this problem is to retire to the easy chair in the living room and relax for about two hours watching television.

Another article I read mentioned that lack of nerve control hampers proper eye dilation. When I leave my home, I notice that my eyes adjust slowly to the sunlight.

Many diabetics have diabetic retinopathy, a condition resulting in hemorrhages or swelling of the blood vessels within the eyeball. This is caused by lack of blood flow.

Most of my problems are not exactly curable. Also they mimic other problems and make it difficult for doctors to treat or diagnose. But all of them can be minimized by good blood sugar control.

# Diabetes quiz

by Christine L. Valenta, RN, MPH, CDE

Christine Valenta is a diabetes clinical nurse specialist and a certified diabetes educator at St. James Hospital and Health Centers in Chicago Heights, Illinois.

*This quiz will enable you to evaluate your level of knowledge about diabetes, both Type I and Type II.*

*This is a True/False quiz. After the question, check either the T or the F and go to the next page for the correct answers.*

1 In Type II diabetes, blood glucose is not able to enter the body's cells because the pancreas makes little or no insulin. T_ F_

2 Destruction of insulin-producing cells in the pancreas can begin years before Type I diabetes is diagnosed. T_ F_

3 Almost 80 percent of all people with Type II diabetes are obese. T_ F_

4 Children and teenagers who develop diabetes always have Type I diabetes. T_ F_

5 Many people with Type II diabetes need only to follow a diabetes meal plan and participate in a regular exercise program to manage their disease. T_ F_

6 Children with Type I diabetes are at risk for a deficiency in height growth. T_ F_

7 Once a person with diabetes begins insulin injections, that person will always require insulin injections. T_ F_

8 The most common symptoms of Type II diabetes are: blurred vision, extreme thirst, frequent urination, tiredness and weakness, weight loss and slow-healing wounds. T_ F_

9 Diabetes, either Type I or Type II, is a disease that is inherited from one or both of your parents who have diabetes. T_ F_

10 A person can have symptomless diabetes for many years before a diagnosis is made. T_ F_

11 Persons with diabetes are more likely to develop high blood pressure (hypertension) than those without diabetes. T_ F_

12 Most people with newly diagnosed Type II diabetes quickly cope with their diagnosis, and adjust their lifestyles so that they can effectively manage this disease. T_ F_

13 About one million people in the U.S. have undiagnosed Type II diabetes. T_ F_

14 A woman with diabetes should contact the doctor who cares for her diabetes immediately after she discovers she is pregnant. T_ F_

15 A cure for diabetes can be expected before the turn of this century. T_ F_

(Note: These questions appeared in the August 1991 issue of *Diabetes in the News (DITN)*, courtesy of DITN.)

(Answers on page14)

# The *Voice* can be your voice absolutely free

(Continued from page 1)

unique benefit is available only to members.

• Free counseling is offered to blind persons and their families regarding all aspects of blindness. Often this includes adjustment techniques for the newly blinded as well as alternative techniques that the blind need to know and use to enjoy life, be active and involved in the mainstream.

• Members are entitled to access all services of the NFB including low interest small business loans and low interest loans to obtain technology that aids the blind. In a nutshell, the NFB is an advocate for the blind with the mission of serving blind people.

*INDEED MEMBERS OF THE DIABETICS DIVISION SUPPORT AND INFORMATION NETWORK RECEIVE MANY BENEFITS INCLUDING THE* **VOICE!**

Most persons want membership; however, some do not. Persons not wishing membership can still receive issues of the ***Voice*** without charge. The Diabetics Division is always eager and willing to provide medical facilities with information about any aspect of diabetes and/or blindness.

To reiterate, the ***Voice*** is now free upon request to any interested person. When ordering the publication, please specify the desired format: print, one-half speed audio cassette or both. The tapes are recorded at a slower-than-standard speed and require a special tape player available without charge to the blind and physically handicapped. To begin receiving the ***Voice***, complete the subscription form (or a facsimile) on page 20 and mail it to the ***Voice of the Diabetic*** editorial office.

# Diabetes quiz answers

(From page 13)

SCORING

**13-15 correct answers:**
Great! You certainly have been doing things right; keep up the good work. Remember that scientific knowledge changes rapidly. What is modern today is obsolete in two or three years.

**9-12 correct answers:**
You just passed and apparently know the basics about diabetes. But you still have plenty of room for improvement. You can never overdose on diabetes education.

**0-8 correct answers:**
Tsk, Tsk. You haven't kept up with your diabetes education. Plan to enroll in a diabetes education class at your local diabetes center, hospital or diabetes association. Start reading all of those diabetes books and magazines that you have accumulated over the years.

**1 False.** The body may be making enough insulin, but the cells cannot use this insulin effectively (for a number of reasons). Following a modern management plan may help improve your body's ability to effectively use the insulin it produces.

**2 True.** Destruction of the insulin-producing cells in the pancreas can start years before symptoms appear and Type I diabetes is diagnosed. It is not until 80-90 percent of these cells are destroyed that blood glucose levels rise so far above normal that this type of diabetes can affirmatively be diagnosed.

**3 True.** Obesity and Type II diabetes seem to go hand in hand. Obesity often triggers the start of Type II diabetes and certainly interferes with the person's ability to control the disease.

Even a modest weight loss will enable the person to make a marked improvement in blood glucose levels.

**4 False.** Although most children and teens usually develop Type I diabetes, some may develop Type II. And, although Type II diabetes is the kind that strikes adults most frequently, some adults can develop Type I diabetes late in life.

**5 True.** On paper, all that is needed by most people with Type II diabetes is proper food intake and regular exercise; the goal is to get rid of excess pounds and keep them off.

Type II diabetics who can do this through changes in their food intake and physical activity level will be able to control their disease.

However, many people with Type II diabetes can't seem to lose excess pounds on a permanent basis.

These individuals, and others with Type II, may require a bit of extra help to control blood glucose by taking an oral hypoglycemic agent. And some people with Type II may require insulin, alone or in combination with an oral agent.

**6 True.** A deficiency in growth is seen in about 10 percent of children with Type I diabetes. This usually occurs in children who have developed the disease at a very early age and in those who have poor blood glucose control. This risk can be lowered by improving blood glucose control through diet, exercise, medication and monitoring.

**7 False.** The answer depends upon the type of diabetes you have and the progress that scientists are making in the diabetes field.

Some people with Type II require insulin injections to maintain control during periods of physical or emotional stress (such as infection, surgery, injury, loss of a family member, change in job or home).

Once they get through these stressful periods, these people are often able to stop insulin injections and go back to the type of treatment they were using before the stress started.

Some people with Type II diabetes sometimes need the extra help provided by insulin injections to bring their blood glucose levels under good control. Once this is achieved, they may be able to return to the previous method of treatment.

And still others with Type II, who are obese or greatly overweight, may require insulin for control — but may be able to stop or reduce the dosage of insulin after they have lost excess pounds.

For people with Type I diabetes, the insulin injection picture is more complex and dependent on many *if's*.

If scientists can develop a safe and effective way of insuring insulin delivery, Type I's may someday be able to take an insulin pill or use an insulin nasal spray.

If scientists can develop an implantable glucose sensor that is 100 percent effective, Type I's may be able to have an insulin pump/glucose sensor implanted within their bodies that requires refills of insulin only every few weeks.

If scientists can develop a safe and effective antirejection drug, Type I's may be able to have insulin-producing beta cells, or segments of a pancreas, implanted in their bodies — freeing them from dependence on insulin injections.

**8 True.** These are the classic symptoms of diabetes (both Type II and Type I). These symptoms are caused by above-normal blood glucose levels.

Unfortunately, many persons don't feel these symptoms when their blood glucose is moderately above normal (200-300 mg/dL) and long term damage is being done; they only feel poorly when their blood glucose is in the 300-400 mg/dL range.

That's why self blood-glucose monitoring is so helpful in detecting minor problems before they become major ones.

**9 True.** Scientists believe that inheritance does play a role in the development of both types of diabetes, but in different ways. Type II diabetes seems to develop in families and has a genetic link.

That's why having a family member with Type II diabetes puts all offspring of that family at risk. At highest risk are brothers and sisters of a family member with Type II.

Scientists also believe that the gene for Type I diabetes may be passed from parent to child. For Type I diabetes to develop, a child must receive a diabetes gene from each of the two parents.

If you have Type II diabetes, it's not only important that you reach and maintain your ideal weight, it is also important that you raise your children in a lifestyle that stresses healthy eating and regular exercise.

**10 True.** The symptoms of diabetes may not show up for years after the blood glucose levels go up and beyond the normal range. Getting regular physical examinations, which include measurement of fasting blood glucose levels, is a good health recommendation for all adults.

**11 True.** Nearly three out of every four Type II diabetics suffer from high blood pressure (hypertension). Both the diabetes and the hypertension put the person at risk for heart disease and strokes.

For the person with diabetes, hypertension can speed up the development of eye and kidney diabetes complications. Losing excess weight should have number-one priority for the person with both hypertension and diabetes.

Taking blood pressure medication and following a low salt diet, if prescribed, also is highly recommended.

**12 False.** Many people don't take the early stages of Type II diabetes very seriously.

That's a mistake, because early treatment of the disease (before permanent damage is done to blood vessels and nerves) can be highly effective.

But people who have newly diagnosed Type II diabetes usually are middle-aged adults who have well-established lifestyles. Learning how to follow a new eating pattern and starting on a regular exercise program are very difficult for someone who has had the familiar (but unhealthy) habits for four or more decades. Learning about diabetes and learning how to make healthy lifestyle changes take quite a bit of time and effort.

**13 False.** The one million number is far too low. The American Diabetes Association estimates that there are more than six million people in the U.S. who have diabetes (almost all have Type II diabetes) and don't know it.

As one of millions who has been diagnosed with diabetes, you may wish to take a leadership role in public education activities in your community that are designed to alert people to diabetes and the need for blood glucose testing.

Check with your local ADA if you have an interest in becoming involved in this sort of activity.

**14 False.** You need to discuss your plans for a future family with your diabetes doctor **before** you become pregnant. It is quite important that you start off your pregnancy on the right foot. You need excellent blood glucose control, and a special management plan that will ensure that your pregnancy runs smoothly and that your baby-to-be will develop normally.

**15 False.** Don't count on scientists finding a cure for diabetes during the next few years.

By the beginning of the next century, scientists may develop ways to prevent or slow the development of Type I diabetes, and may even develop some drugs that are effective in preventing or slowing some kinds of Type II. There will be improvements in transplants, insulin delivery systems and other aspects of diabetes management. But there will be no magic that will cure the diabetes that affects your body.

Rather than spend your time wishing for a miracle, you need to work to improve your diabetes control and your lifestyle.

# Dear friends

*The Diabetes Treatment Center of Houston, Texas asked its past and present patients to comment on measures that family members or friends can take to better support the person with diabetes. Only minor editing was made to the following responses.*

*If you have comments that would help others better understand diabetes, please send them to the* **Voice** *editor.*

*** Please understand how important a role diet plays in managing my diabetes and what this type of control means for my health years from now. It is an important change I must follow for life.

*** When my blood sugar is under control, you cook sweets that I love. You eat a small amount and leave the rest to torment me. Please help me by not cooking foods with a lot of sweets.

*** Please don't tempt me with sweets and other foods I shouldn't eat, and make sure snacks are not high in fat.

*** Friends and family often do not understand the need to be informed of the diet that a diabetic must follow to keep their condition under control. It is very difficult to say "no thank you" when foods are offered that are not on one's diet.

# A letter to the editor

Grand Ronde, Oregon
January, 1992

Ed Bryant, Editor
***Voice of the Diabetic***

Dear Fellow Diabetics,

I'm a 32-year-old male who has had Type I insulin-dependent diabetes for 25 years. Although I have had several complications due to diabetes, treatments have been very successful.

At 23 years of age, I started to develop diabetic retinopathy in both eyes. I started laser treatments in September 1982. The treatments lasted eleven months and did save most of my central vision, but I lost nearly all peripheral (side) vision. My vision is now 20/25 in the left eye and 20/20 in the right eye. If you need this treatment, I recommend you have it done. My ophthalmologist had told me that I would be legally blind in two months.

Then, in 1986, I had a kidney transplant. I waited only five days for it. To this day, I have not had a rejection episode.

Also, I had angioplasty in 1988. In 1989, I had my gall bladder removed. In 1990, I had double bypass heart surgery. The only complication I developed from the bypass was walking pneumonia. I feel very lucky compared to others.

I am going to have a pancreas transplant. I believe in the staff's ability at my hospital, Oregon Health Sciences University. They have done eighteen pancreas transplants, and thirteen are still working. Those are very good numbers. I would also like to mention that Blue Cross and Kaiser Permanente cover this procedure.

I've also had severe neuropathy in my feet. Nothing would end the burning, tingling sensation until I was introduced to an over-the-counter vitamin, Inositol, that actually cured me. I took 1000 milligrams of pure Inositol three times a day for a month. I've been free of the burning and discomfort of neuropathy for over four years. It's very inexpensive, but it works. I know.

I hope I've encouraged you somewhat and not discouraged or depressed you in any way. In life, we always have options.

Good luck,
Roger Shoff

*From the Editor: All diabetics are at risk of losing vision and going blind from diabetic retinopathy. However, it usually takes 15 years or more for substantial loss of sight to develop. It can be difficult for a person leading an active lifestyle to be unable to drive their automobile or read normal size print clearly because of blindness. Blind men and women, with opportunity and the use of alternative techniques, can continue being active citizens.*

*Our organization, the National Federation of the Blind, with more than 50,000 members, is the largest group of organized blind persons in existence. We serve all blind people and offer numerous publications and literature covering all aspects of blindness. Many appliances are available, such as long white canes (at just enough to cover our costs), to serve the blind. The NFB offers comprehensive information about programs set up to assist the blind, such as Social Security Disability Insurance, and we cosponsor with the U.S. Department of Labor a job referral program, "Job Opportunities for the Blind." This program has helped more than 1,000 blind job seekers find employment.*

*We have a positive philosophy and can show blind persons and those losing vision how they can continue to be active, productive members of society. Blindness is not synonymous with disability, and it is well documented that limitations are usually self-imposed.*

# Travel tips for blind diabetics

**by Marianne Winsky White, Ed.S.**

Long distance travel has become an integral part of our American lifestyle. Both business and pleasure trips frequently take us from our familiar environments. With planning, individuals who are blind and diabetic need not hesitate to actively participate in our on-the-move society. The following travel tips may assist in planning a safe trip:

Obtain a letter from a doctor stating your diabetic condition. This is helpful if traveling with syringes, especially in foreign countries.

Obtain prescriptions in advance from the doctor; prescriptions often vary from state to state and country to country.

Obtain immunizations at least a month in advance to ensure a reaction does not interfere with your diabetes control.

U-100 insulin and syringes are sold only in the United States, Canada, Australia, and New Zealand. Disposable syringes are best for travel.

Insulin is stable and does not need to be refrigerated; it can withstand the same temperatures the body can withstand. Never stow insulin in the luggage compartment of an airplane, as it may freeze.

Always wear and carry identification that includes the type of diabetes.

Carry a snack pack containing carbohydrates, protein, crackers, cheese, peanut butter, fruit, and some form of sugar in case of an insulin reaction.

Before traveling across time zones, plan with your doctor a schedule for insulin injections.

Do not sit for long periods while traveling; get up and stretch at least every two hours to improve circulation.

Airlines will accommodate special diets and any special meal times if requested at least six hours in advance.

Stick as closely as possible to your regular meal schedule.

Adapted from: "What You Need to Know About Diabetes," American Diabetes Association, Inc.

**(Editor's Note:** The preceding advice is good for all diabetics regardless of whether you are blind or sighted. All diabetic people can travel anywhere they desire.)

# Holiday survival

**by Carolyn Dennis, R.D., C.D.E.**

No one needs to be reminded that the holiday season is once again upon us. Just as taking time to do some planning will alleviate last minute hustle-bustle and overindulging on gift buying, so too will it help prevent skyrocketing blood sugars and skintight clothes come January.

Some say that anticipation is half the fun of the holiday season. Anticipating the mouth-watering temptations awaiting you at office parties, church dinners, open houses, and festive gatherings may well be the key as to how you'll weather this holiday season.

First, don't arrive at the party on an empty stomach. If possible, try to eat a high fiber snack (filling) before leaving home so you won't feel ravenous enough to demolish the appetizers. There really are no forbidden foods, just remember to eat in moderate amounts on this occasion. When we think of foods as "forbidden," that often only serves to make them seem more appealing. Remember, *moderation* is the key to healthy holiday enjoyment!

The two main ways we raise blood sugar levels are by eating sweets and just plain overeating. We usually get too many calories not just from the amounts of food we eat, but also by making high fat (therefore high calorie) choices. Ever eaten this much on a holiday?

| | Calories |
|---|---|
| 2 pieces toast/1 egg | 250 |
| stuffed celery | 225 |
| 1 glass cider | 150 |
| 10 crackers with cheese | 700 |
| 2 alcoholic drinks | 300 |
| 3 handfuls of nuts | 800 |
| 2 servings of turkey | 400 |
| mashed potatoes | 200 |
| 4 or 5 ladles of gravy | 1000 |
| candied sweet potatoes | 200 |

| | Calories |
|---|---|
| 1 helping squash | 50 |
| 1 helping sauteed green beans | 150 |
| cranberry sauce | 150 |
| 1 roll | 100 |
| 3 T. butter | 300 |
| 2 helpings stuffing | 600 |
| 2 pieces pie | 800 |
| 3 cups coffee with cream and sugar | 150 |
| 6 pieces of fudge | 1500 |
| **TOTAL** | **8025** |

The above chart represents a typical, day-long blowout, including a small breakfast, the main meal, and evening snacking on leftovers. When you consider that 3500 excess calories generate a pound of fat, that a 125-pound woman needs only 1400 calories to maintain her body weight, that a 175-pound man needs approximately 2100 calories a day to maintain his; then it's no mystery why the average person gains weight so easily and finds controlling blood sugars a struggle during the holidays.

Before you put that fourth Christmas treat in your mouth, stop and think for a moment about whether that's what you really want and why you're eating it. Are you frustrated with your family? Would a brisk walk or a phone call to a friend meet your needs more directly? Perhaps taking time to pamper yourself is what's really needed: a long bath, quiet time to read, or a nap. Geneen Roth's excellent book, *Breaking Free From Compulsive Eating*, suggests that we all overeat compulsively on occasion, and examines ways for us to break that cycle by learning to differentiate our hunger from our habits and our needs. (You might want to buy it for yourself as a holiday gift!)

Remember too, that the holidays revolve around much more than what we put in our mouths. What a perfect time to reach out to others: do some volunteer work, visit someone who can't get out, renew old acquaintances, take time to do something special for yourself; the possibilities are endless. Here's wishing you a healthy and happy holiday season and New Year!

(Note: This article appeared in the *Kentucky Diabetes News*, published by the Kentucky Diabetes Foundation, Lexington, Kentucky.)

# Deciphering food labels

## It's the fine print that tells the real story of what you're eating.

by Deborah Beroset Diamond

Stroll down the aisles of any supermarket, and you'll encounter shelf after shelf of boxes, bottles and cartons screaming at you in bold, colorful type: This one's fat free, that one's "lite", and hey, that one over there is high in fiber and low in salt. Surely you can't go wrong buying such healthy-sounding products, right?

Not necessarily, says Diane Mosher, registered dietitian at University of Missouri Hospital and Clinics.

The peanut butter that claims to be cholesterol-free isn't any better for you than the generic brand because neither one contains any of the vessel-clogging stuff. But both are high in fat, Mosher notes. "The current labeling practices can be misleading," she says, adding that companies tend to prey upon consumer fears and fads in order to present their products in the best light possible.

The trick is to know how to read the nutritional labels. But the scientific jargon and inconsistencies you're likely to find there can make deciphering the information harder than finding a shopping cart without a wobbly wheel.

Fortunately, Mosher says, the Food and Drug Administration is cracking down on food companies. The federal agency has proposed strict labeling regulations that will allow you to compare at a glance the levels of fat, sodium, calories, cholesterol and fiber in the foods you buy. "If there's something you're trying to cut down on and it's among the first three ingredients listed, you're probably better off making another selection."

*Sugar can be sneaky.* When determining sugar content, keep in mind that it can come in lots of forms, including corn syrup, honey, molasses, and words that end in "-ose," like dextrose and fructose. Until the new laws are in effect, products may list several different forms of sugar, which individually weigh proportionately little and therefore come at the end of the ingredients list. (The new FDA rules require sugars to be grouped together, which typically places them higher on the ingredients list and makes it easier to compare products for sugar content.)

*Is it no-salt or no-sodium?* Just as sugar travels in many disguises, so does salt. A product claiming to be no-salt may still contain high levels of sodium. Be alert to ingredient names with the word sodium (like sodium nitrate) as well as additives such as monosodium glutamate, calcium disodium phosphate and EDTA.

*Beware of empty promises.* Many terms like "natural" and "light" are meaningless apart from their proven ability to attract health-conscious shoppers. "There's currently no legal definition of those terms," Mosher says. "They're often just a marketing gimmick. You really have to determine for yourself which product is the better choice."

The new rules provide standard definitions for terms such as "light," "low-calorie," and "low-fat," and require realistic, standardized serving sizes. In addition, the FDA will have strict criteria for health claims (such as the ability to prevent cancer, for example) and will require nutrition information on nearly all packaged foods.

The new laws won't apply to meat and poultry products, which are regulated by the Department of Agriculture. (Separate labeling regulations are expected for those foods.) The rest of the food industry, however, will have to comply with the new labeling laws by 1993.

Meanwhile, though, we have to rely on the current food labels. Health-minded consumers who want to know more about what they're eating can follow Mosher's advice:

*Remember ingredients are listed in descending order of predominance, by weight.* "If the first ingredient on a kids' cereal is sugar and not a grain product, you know that product is made mostly of sugar," Mosher says.

*"Reduced calories" can still put on pounds.* By law, the term "reduced calories" can only be used if the item has one-third less calories than the original product, Mosher explains. "But the original salad dressing or whatever might be so high in fat and calories that the one-third isn't a big deal."

*"No cholesterol" does not mean no fat.* Cholesterol is only found in animal products, Mosher explains, which means vegetable oils and other plant products are "no-cholesterol", by definition. "Potato chips fried in vegetable oil contain no cholesterol but they're still very high in fat," she says.

Even though plant products don't contain cholesterol, some of them do raise blood cholesterol levels. Give preference to oils containing either mono — or polyunsaturated fats instead of saturated fats, which are found in high concentrations in butter, lard and tropical oils (palm and coconut).

"But the overall goal is to lower the percentage of calories from fat, regardless of what kind of fat it is," Mosher says.

*Don't be seduced by the "percent fat free" claims.* That lunch meat or frozen dessert that's "90 percent fat free" might look like a good choice, but it may not be, Mosher points out. These claims, a popular marketing ploy, are based on the weight of the product, rather than the more relevant percentage of calories. Odds are the dessert that claims to be "90 percent fat free" gets more than half its calories from fat.

*Always check the serving size.* Most cereal boxes list 90 to 110 calories per serving, but the serving sizes used to calculate those figures range from one-quarter cup to a cup and a quarter. "You can't just compare calories or fat or sodium without taking the serving size into account," Mosher warns.

To illustrate, she holds up two frozen entree boxes. At first glance the creamed chipped beef, with 240 calories listed, would appear to win out over the chicken a l'orange at 270 calories. "But the chipped beef entree contains two servings, whereas the other box contains one serving," Mosher continues. "If I ate the food in this box — which is the same size as the other one — I'd really be consuming 480 calories."

*As a general rule, choose a variety of foods and eat moderate portions.* If you're not good at eating by the numbers, adopting this practice will help minimize excessive fat, cholesterol and sodium in your diet, Mosher says.

The important thing, she adds, is to take the time to be sure you know what you're purchasing. It may not be easy to glean guidance from a nutritional label, but it certainly is possible with a little practice. "I tell folks not to read the advertising on the front of the package," Mosher says. "But if you understand what's in the nutritional panel, you won't be misled."

There's a saying that holds true whether you're buying life insurance, real estate or an unassuming jar of pickles: It pays to read the fine print.

(Note: This article appeared in the Winter 1992 issue of *Caring*, published by the University of Missouri Hospital and Clinics, Columbia, Mo. Courtesy of Deborah Beroset Diamond.)

Ann Terry is a registered dietitian who works at the State Hospital in Fulton, Missouri and at the Veterans Administration Hospital of Columbia, Missouri. She graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

### Mary's Chicken/Turkey Surprise

From Mary Leone
of New Britain, Connecticut

18 oz. chicken/turkey, skinned and boned
12 small potatoes, peeled
2 medium carrots, peeled
8 medium onions, peeled and sliced in half
6 medium apples, cored
4 cloves garlic, cut up
1/2 tsp. salt (optional)
seasoning
2 cups vinegar
1 tbsp. pure olive oil

Place meat in mixing bowl and marinate in vinegar and garlic cloves for about 2 hours, add 1/2 tsp. salt. Let stand, remove meat and discard mixture. After skinning meat rinse under running water. Place meat in shallow baking pan. Add olive oil, potatoes, carrots, and onions. Season to taste using Mrs. Dash, pepper, parsley, or other spices of choice. Place apples in baking pan. The chicken/turkey will absorb the apple flavor and prevent from drying out. Bake at 400 degrees for one hours.

Yield: 6 servings. Calories: 425. Diabetic Exchanges: 3 lean meat, 2 bread, 1 vegetable, and 1 1/2 fruit.

### Meatballs

From Debra Knight
of New Britain, Connecticut

1/2 cup skim milk
1-1/2 lbs. lean ground round beef or turkey
1/2 cup onions, chopped
3 slices bread, cubed
1 egg
1 tsp. salt (optional)
1 tsp. pepper
1 tsp. Mrs. Dash
1 tsp. garlic powder

In large mixing bowl combine the meat, egg, and spices. In a small mixing bowl add the milk, onion, and bread cubes, letting the mixture in the small bowl sit for five minutes. Add this to the large mixing bowl, and mix well. Shape mixture into balls and bake them for 25 to 30 minutes in a 350 degree oven. This should make 4 1/2 dozen meatballs; portion out and put into freezer for additional meals.

Yield: 8 servings. Calories: 230. Diabetic Exchanges: 2 lean meat, 1 bread.

### Orange Sherbet

Appeared in *The Free and Equal Sweet Tooth Cookbook,* courtesy of Surrey Books.

3 cups skim milk
2 cups orange juice
2 tablespoons lemon juice
1 tablespoon grated orange rind
1 envelope unflavored gelatin
10 packets Equal

In large mixing bowl, combine all ingredients. Process in an ice cream maker according to manufacturer's directions. You can also pour into shallow pans, cover, and freeze until almost firm. Place in a large, chilled mixing bowl and beat with electric mixer until smooth. Return to pans. Cover with foil and freeze until firm. Makes about 1 1/2 quarts.

Yield: 12 (1/2 cup) servings. Calories: 46. Diabetic Exchanges: 1/2 bread.

# Join the NFB Network and make a difference for the blind!

**Sharon Gold serves as chairperson of the National Federation of the Blind telephone network. She is also president of the NFB of California.**

***Introducing the NFB NETWORK:*** On behalf of the National Federation of the Blind we are pleased to offer this exceptional opportunity that will serve both you and the National Federation of the Blind. This simple but exciting offer is a viable, proven alternative to traditional long-distance phone service. With the NFB NETWORK, you can donate money from your long-distance phone bill and ***it won't cost you a penny!***

**Here is how the NFB Network works:**

• The NFB Network Long Distance rates are never higher than AT&T's standard "Dial 1" rates, plus you receive a **10% discount** on top of that.

• The NFB Network will let you **pass along 1/2 or all** of your discount as a **tax-deductible donation,** in your name, creating a perpetual source of new funds to support the National Federation of the Blind. (The donation is made automatically each time you pay your NFB Network phone bill.)

• This program is *UNCONDITIONALLY GUARANTEED!* There is no risk to you, no sign-up fees, and no cancellation fees. If you are not completely satisfied with the quality of service you receive, you may cancel at any time and we'll pay to switch you back.

If after reading this information, you still have any questions, call the NFB NETWORK at 1-800-848-2661 to get a prompt answer. Or call to sign up!

P.S. Remember, your satisfaction is guaranteed! There is nothing to lose and much to gain by joining this program. JOIN US!

*To order an enrollment card or sign up call: 1-800-848-2661.*

***More benefits of the NFB Network:***

• The NFB NETWORK gives you a billing statement each month that shows you exactly how much you have contributed to the National Federation of the Blind.

• Enjoy top quality "Dial 1" long-distance phone service at competitive rates.

• Participate in a unique, proven program that can provide significant support for the National Federation of the Blind.

• Enrollment in the NFB NETWORK also includes a *FREE CALLING CARD* for calling when you're away from home. Free calling cards are also available for other family members upon request.

## *IMPORTANT ENROLLMENT INFORMATION*

Please note the following as you fill out the enrollment form, or if you call in your enrollment:

*1* - The name on your subscription form must be exactly as it appears on your local telephone bill (compare with your current phone bill).

*2* - For the program to be effective for you and the NFB, subscribers should average over $10.00 per month in long distance billings.

Call us at ***1-800-848-2661*** or ***918-660-0222*** if you have any questions.

The *NFB NETWORK* is provided by Convergent Communications, Inc. which has arranged with AT&T and other major carriers to use their networks and calling card validation databases for this program. Convergent Communications is responsible for all services in connection with the program, including billing, collections, and reporting lost or stolen cards. Residential "Dial 1" service is available in most areas of the U.S.

Taxes, credits, international calls, and certain calls which, by FCC regulation, must be handled by your local phone company do not qualify for discount calculation. Your local telephone company may charge a nominal fee to switch your long distance carrier. If so, a credit will be issued to your account upon request.

# What you always wanted to know but didn't know where to ask

**(Resource list)**

(Inclusion of materials in this publication is for information only and does not imply endorsement by the Diabetics Division of the NFB.)

**What's Coming Up**

In the next issue of the ***Voice,*** Volume 8, Number 1, Winter 1993, there will be an evaluation of all glucose monitoring systems with audio output manufactured in the United States. This review will be comprehensive, providing strong and weak points of each system along with other specific details.

**Review**
by Ed Bryant

I have reviewed the two Count-A-Dose insulin measuring devices manufactured by Jordan Enterprises and found them very easy to use. Each unit is constructed from sturdy plastic and is extremely durable.

One Count-A-Dose device measures in one-unit increments and the other in two-unit increments. As insulin is being drawn, an audible click is heard for each one or two units drawn. Each Count-A-Dose unit holds one or two bottles of insulin for mixing and the needle penetrates the bottle stopper automatically. One unit measures insulin in B-D U-100 1/2-cc (low dosage) syringes; while the other measures insulin in B-D U-100 1-cc syringes.

I have used the Count-A-Dose instruments for three months and recommend them to blind consumers. Print and easy-to-understand cassette instructions are provided. The suggested retail price for each unit is $49.95. However, if orders are made from Maxi-Aids and you tell the distributor you heard about the product in the ***Voice of the Diabetic,*** you can receive the unit at the reduced cost of $44.95 plus $3.00 shipping. Order from: Maxi-Aids, 42 Executive Blvd., Box 3209, Farmingdale, NY 11735; telephone toll free: 1-800-522-6294.

**Annie Weems serves as chairwoman of the NFB Diabetics Division committee on: Resources-Aids and Appliances.**

**New Resource List**

The Diabetics Division of the NFB has an updated resource list of aids and appliances for blind diabetics and those losing vision. This list is comprehensive and is arranged under five general headings: General and Miscellaneous, Automatic Insulin Injection Systems, Blood Glucose Monitoring Systems, Insulin Pumps, and Large Distributors of Diabetes Equipment/Supplies.

Sometimes blind diabetics do not realize that they can continue being independent by accurately drawing up insulin and testing blood glucose levels. Limitations are usually self-imposed and often all that is needed to overcome negative thinking is simply knowing where to go for information.

The new resource list costs $1.00 per copy and is available in Braille, print, and cassette. Make donations payable to National Federation of the Blind and order from: Annie Weems, Aids and Appliances Chairwoman, 24269 Leewin, Detroit, MI 48219; phone: (313) 592-1567.

(Continued on page 18)

## What you always wanted to know

(Continued from page 17)

### Winners

At the 1992 annual convention of the NFB in Charlotte, North Carolina, Home Diagnostics Inc. of Eatontown, New Jersey unveiled the "Diascan Partner," a glucose monitoring system with voice output. Five people won a new glucose unit from the drawing held by Home Diagnostics. Winners were: Greg Beach of Fargo, ND; Mary Galligan of Omaha, NE; Karen S. Mayry of Rapid City, SD; Debra Sutcliff of Staunton, VA; and Daryel White of Valley Park, MO.

The new "Diascan Partner" is easy to use and will be on the market by January 1993. With the new system, blood can be smeared on the reagent strip pad, while still obtaining an acceptable clinical reading. The "Diascan Partner" weighs eight ounces and comes with an over-the-shoulder tote bag at a suggested retail price of $399. For information contact: Home Diagnostics Inc., 51 James Way, Eatontown, NJ 07724; telephone: 1-800-342-7226.

Congratulations to the winners! Your new "Diascan Partner" should help keep your diabetes under control.

### Literature

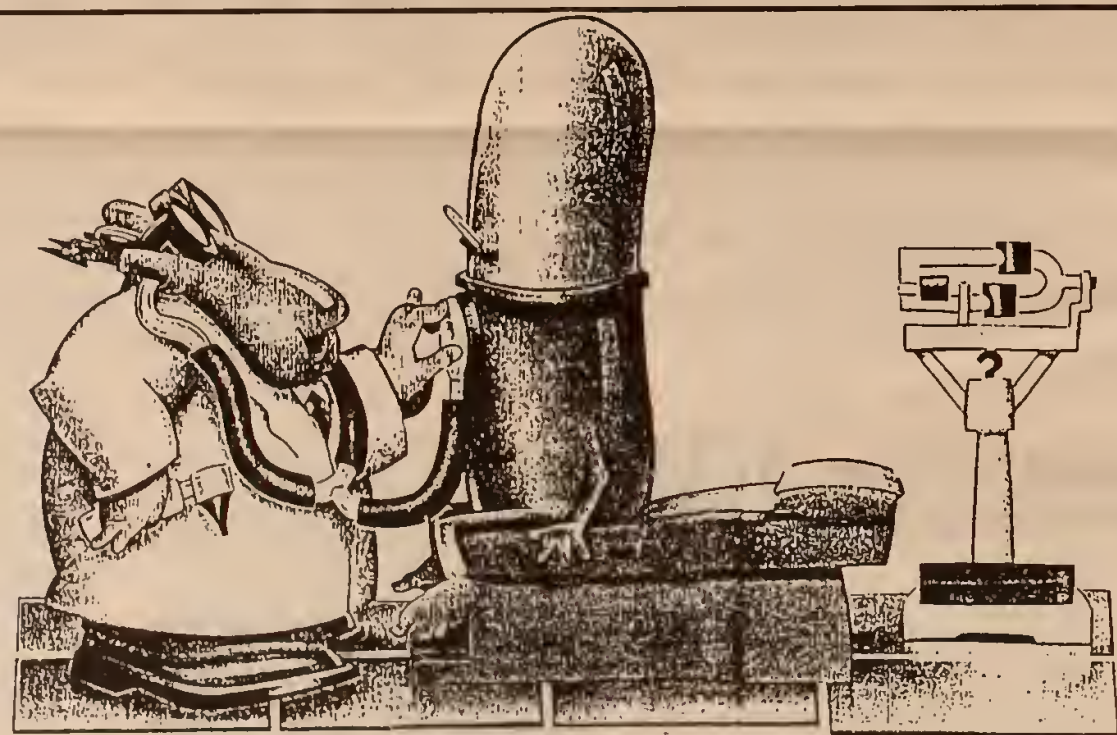
*Diabetes Fare: Recipes for a Healthy, Sugar-free Diet:* This 125-page spiral bound cookbook is broken down into the following categories: Appetizers and Beverages, Soups and Salads, Entrees, Vegetables, Breads/Pastas and Other Starches, and Finales. The yield, estimated nutrients per serving and exchanges per serving are listed with each recipe. This book contains several helpful information pages for conscientious meal planners which include: a handy spice and herb guide, microwave hints, several pages of helpful kitchen hints and some easy cleanup ideas. It also contains charts such as: iron content of some common foods, measurement equivalences, substitutions for missing ingredients, an oven chart, common can sizes and a list of sugar substitutes that contain no calories.

Loaded with recipes appropriate for diabetics, *Diabetes Fare* has much additional information covering different aspects of meal planning and preparation. This recipe book is recommended not only for diabetics but any health conscious person. Cost: $6.00 plus $1.75 shipping. Order from: Columbia Regional Hospital Public Relations Dept., 404 Keene St., Columbia, MO 65201; telephone: (314) 875-9500.

*Diabetes Interview:* This quarterly magazine reaches professionals and people with diabetes. Part of the publication's mission statement says: "Our goal is for all people with diabetes to lead a healthy and fulfilling life." As ***Voice*** editor, I have reviewed *Diabetes Interview* and recommend it to anyone interested in diabetes. It provides updated information regarding health and diabetes care. The magazine cost per year: $14. Order from: *Diabetes Interview*, 3715 Balboa St., San Francisco, CA 94121; telephone: 1-800-473-4636.

*Impotence Article:* In the Spring, 1992 issue of the ***Voice***, an article appeared titled, "Diabetic Men, Impotence and How to Prevail." Copies of this article have been requested by many individuals because it provides useful information. For a free print copy send a S.A.S.E. or for an audio cassette version send $1 (payable to the National Federation of the Blind) to: Resource Library Committee of the Diabetics Division of the NFB, Chairwoman, Cheryl McCaslin, 7717 Eastern Ave., Apt. B, Dallas, TX 75209; telephone: (214) 352-4974.

*Living Well on Dialysis* by the National Kidney Foundation (sponsored by Amgen, Inc.). There hasn't been a good renal cookbook for diabetics because many recipes are high in sugar and/or fat. If one is a well controlled diabetic, it may be difficult mentally to adjust to a renal diet. About 30 percent of dialysis patients are diabetic which means that about fifty thousand are on dialysis. Now that *Living Well on Dialysis* is available, diabetics can more easily keep their diabetes in check. Many of the recipes have low to moderate sugar and fat content and they all show servings, calories, diabetic exchanges and nutritive values for renal diets. Interested consumers should check with their nephrologist or local dialysis unit to obtain a copy of *Living Well on Dialysis*. Many dialysis units provide this book free of charge to patients.



**DON'T BE A DISCONTENTED DISCONTENT: KEEP YOUR DIABETES UNDER CONTROL**

Watch your diet, take medications as prescribed, and exercise regularly.

# Food for thought

*We invite blurbs and tidbit articles for inclusion in this column. Materials received may be edited and used as space permits.*

***What Are Seniors Worth Anyway? We Are Worth A Fortune!***

*This piece was received from Michelle Davis of Salina, Kansas. The author is unknown.*

Remember older folks are worth a fortune, with silver in their hair, gold in their teeth, stones in their kidneys, lead in their feet and gas in their stomachs.

I have become a little older since I saw you last and a few changes have come into my life since then. Frankly, I have become quite a frivolous old gal. I am seeing five gentlemen every day.

As soon as I wake up, Will Power helps me get out of bed. Then I go to see John, then Charlie Horse comes along, and when he is here he takes a lot of my time and attention. When he leaves, Arthur Ritis shows up and stays the rest of the day. He doesn't like to stay in one place very long, so he takes me from joint to joint. After such a busy day I'm really tired and glad to go to bed with Ben Gay. What a life!

P.S. The preacher came to call the other day. He said at my age I should be thinking about the hereafter. I told him, "Oh, I do that all the time. No matter where I am, in the parlor, upstairs, in the kitchen or down in the basement. I ask myself . . . What am I Here After?"

### Congratulations!

In an earlier issue of the ***Voice,*** we announced that our Diabetics Division would have a raffle to help defray costs.

We now have a winner, and the lucky person has been sent $200. The winner was Roger Womble of Atlanta, Georgia. Leotha Womble, of Atlanta, Georgia, seller of the winning raffle ticket, was awarded $100, Congratulations, Roger and Leotha!

### Print, Tape or Both?

Most people who receive the ***Voice*** on cassette also receive it in print since it is often shared with friends, family members, doctors and other interested persons. Because education is essential, this publication provides information on all aspects of diabetes, blindness and the National Federation of the Blind.

Please let the editorial office know if you wish to receive the ***Voice*** in a tape format only. Again, most tape receivers want the ***Voice*** in print as well as on cassette but if you can't use the print version please let us know.

### Articles Needed

If you are a health professional, a person with diabetes, a family member, or friend of a diabetic, we invite you to submit an article for publication in the ***Voice of the Diabetic.***

If you have diabetes, have you experienced a diabetic complication? If so, your story can be inspiring and enlightening for thousands of men and women who may be facing the same side effect(s).

One of the goals of the Diabetics Division of the National Federation of the Blind is to show people that they have options regardless of diabetic complications. Are you blind or losing vision? Have you had a kidney transplant? Do you have nerve damage? Have you had an amputation? None of these problems has to be overwhelming. It is helpful to know that others have been down the same road.

If you have doubts about your writing ability, please do not worry. If major changes are needed, you will be contacted before the story is used in the ***Voice.***

All submissions to the ***Voice*** must be upbeat, because our philosophy regarding diabetes is positive. For information and article submission guidelines, contact: Ed Bryant, Editor, ***Voice of the Diabetic,*** 811 Cherry St., Suite 309, Columbia, MO 65201; telephone (314) 875-8911.

### Spread the Word

If you know someone who may be interested in reviewing the ***Voice of the Diabetic,*** let us know and we will send him or her a complimentary print and/or cassette copy (tapes recorded at 15/16 inches per second for the blind and physically handicapped). Contact: ***Voice of the Diabetic,*** 811 Cherry Street, Suite 309, Columbia, MO 65201; telephone: (314) 875-8911.

### Nutrition Hot Line

The National Center For Nutrition and Dietetics provides an information hot line on nutrition staffed by registered dietitians. For information about balancing your diet call toll-free: 1-800-366-1655 between 9:00 a.m. and 4:00 p.m. (Central time) to talk to a registered dietitian, or call anytime for recorded messages concerning current issues in dietetics.

### Correction
by Donovan Cooper

In the previous edition of ***Voice of the Diabetic,*** I presented an article entitled "Financing Transplantation." To the best of my knowledge, the information in that article was correct with one exception. Call it wishful thinking if you will, but I was led to believe that there was a way for some people to save money on insurance premiums while obtaining additional coverage — a way that simply does not exist.

The error applies only in the context of someone who has a health insurance plan that is not an HMO obtained through their employer and is considering obtaining Renal Medicare Part B Medical Coverage in addition to their existing health insurance. Recall that for Medicare Part B you will be charged a monthly premium. Recall also that there is an 18-month period within which your Medicare coverage is secondary to your private insurance coverage after which Medicare becomes primary. Based on my initial discussion with a local Social Security representative, I thought it was possible to time the beginning of your Part B coverage so that you would not have to pay premiums until you receive primary coverage from Medicare. Not so.

Unfortunately, your monthly Part B premiums start with the first month of secondary coverage and Medicare will not become primary until 18 months later. During that first 18 months, Medicare is not likely to pay any benefits in addition to those already paid by your private insurance. When Medicare becomes primary, your private insurance may pay additional benefits in addition to those paid by Medicare but you will have paid 18 months worth of premiums and you will only have, at most, another 18 months of Renal Medicare primary coverage unless you receive another kidney transplant or go on dialysis.

For many people, including me, it will not appear worth the risk of paying the first 18 months' premiums and then hope that your secondary private insurance benefits during the remainder of your Renal Medicare coverage will be greater than the amount you have paid in premiums. That's not what you hope for anyway. You hope for lowered medical and hospital costs over time and that is the most likely scenario.

But it is not a sure thing. So, the lesson to be learned is that you have to assess your own risks and make your own decisions. Don't let me or your transplant center social worker make them for you. I hope that the information in my original article as well as the corrected information in this update is helpful to you. Good luck and good fortune.

### Challenge 2000:

Royanne Hollins is a member of our Diabetics Division and says she has made a commitment to help other disabled individuals establish their own distributorships and has asked us to announce the following:

With an unemployment rate of 75 percent among working-age visually impaired adults, and the present recessionary economy, job opportunities for people with vision loss continue to be limited. That's the bad news, the good news is Matol Botanical International Ltd's "Challenge 2000" program.

This international company offers independent distributorships, including full support and training, to persons desiring to operate their own home businesses. Information is provided for the physically challenged in Braille, large print, on audio cassettes, in transcripts, TDD communications, interpreting services and wheelchair accessibility and are made available at corporate functions.

The company is best known for its Km$^{R}$ product, a potassium mineral supplment developed by Karl Jurak, of Vienna, Austria, in 1922. The product is a rich herbal preparation of nutrients in a natural non-medicinal base that works in conjunction with the body's own system to heighten the state of health. Since the product's introduction to the United States in 1986, the company has grown from $16 million to over $200 million in annual sales.

In January of 1991, Matol introduced the Pathway Nutrition System™ to accommodate an increasing need for better nutrition and fiber in our diets. The system has been used by thousands, successfully utilizing high-fiber, low-fat products for weight reduction and maintenance.

You can purchase an independent distributorship with Matol for around $50. This provides you with all of the rights and privileges of an independent distributorship, as well as a special kit designed for the visually impaired, containing promotional and training materials in Braille, large print, and on audio cassette. There are no quotas, minimal paperwork and excellent tax advantages. The business can be worked full or part-time and substantial royalty incomes can be earned as you build and train your network of distributors.

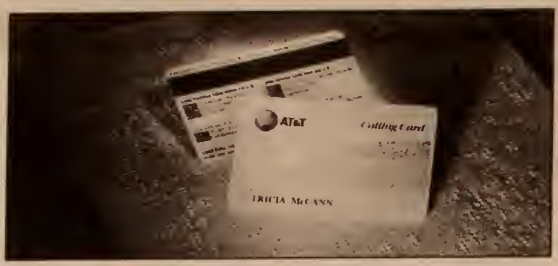
Matol believes that ability — not disability — determines a person's potential. The company places strong emphasis on personal development, and offers ongoing training and materials to help you improve your skills and abilities.

To be successful in this business, your abilities or inclination need not be in sales. If you care about and like helping people, have a positive attitude, are a good communicator and feel you have or can learn teaching skills, this new program may be for you. For information contact: Royanne Hollins, Independent Distributor, Matol Botanical International Ltd., Amherst Place, 1019 Dornajo Way, #135, Sacramento, CA 95825; telephone: 916-929-9271 or 1-800-879-2282.

### The *Voice* on Tape

Diabetes causes many men and women to become legally blind each year, so a ***Voice*** on cassette may be needed. If you are currently receiving the ***Voice*** in print and are having difficulty reading it because of sight loss, you may receive it on cassette at no charge. Tapes are recorded at 15/16 IPS which requires a special tape player. These players may be ordered at no cost from Regional Libraries for the Blind and Physically Handicapped

(Continued on page 20)




## Food for thought

(Continued from page 19)

or by telephoning the National Library Service at 1-800-424-8567. If you wish to receive a different format of the ***Voice*** all you need to do is contact us at the editorial office.

### Braille Calling Card

We have been asked to announce the following: AT&T has introduced a newly redesigned, easy to read, Braille AT&T Calling Card that offers several new features and access to a myriad of services available through the AT&T Worldwide Intelligent Network.

The cards have permanent calling card numbers which enable users to keep the same card, even if they move. This new AT&T braille card allows customers to place local, long-distance and international calls quickly and easily from any phone, without the need to use change. The card also protects customers from higher costs charged by other operator service companies.

Other advantages of using the AT&T Calling Card include access to the following services:

- AT&T USADirect Service and AT&T World Connect Service, which connect overseas travelers to an English-speaking AT&T operator when calling back to the U.S. and around the world.
- Valuable discounts on AT&T Calling Card calls, through the Reach Out America Plan with the Card Discount Option.
- Courteous 24-hour operator assistance.
- Access to innovative technologies such as AT&T Message Service, which enables callers to record messages in their own voice and send them to another phone at any time the caller chooses.
- AT&T Language Link Service, which provides 24-hour, telephone-based access to interpreters who assist customers in more than 140 languages.

AT&T customers also may obtain the Braille AT&T Custom Calling Card, which allows users to call up to ten pre-selected telephone numbers, area codes or countries. Calls placed via this card are charged to the person who established the card account. With this new card, users can reach the most important people in their lives anytime, from almost any phone, without the need for change.

AT&T's Braille Calling Cards are printed in Type II text. "AT&T" is printed in the upper right corner so users can easily identify the card. Instructions, card information and selected promotional materials, provided in Braille print, are included with each new Braille AT&T Calling Card.

Customers who would like more information or wish to order a Braille AT&T Calling Card for the first time can call 1-800-942-6021.

### New Pamphlet

The Diabetics Division of the National Federation of the Blind now has a new pamphlet titled "Diabetes, Complications, Options." This pamphlet is attractive and explains our outreach programs. The publication disseminates essential information and reaches out to anyone who has an interest in diabetes and blindness.

Free copies are available to anyone interested in helping to spread the word. The new pamphlet is great for libraries, pharmacies, physicians' offices, hospitals and so on. "Diabetes, Complications, Options" may be ordered from: The National Federation of the Blind, Materials Center, 1800 Johnson Street, Baltimore, MD 21230; telephone: (410) 659-9314.


## ADVERTISERS

Effective advertising doesn't scream at its audience. It persuades. It sells. The key to cost-effective advertising is making your voice heard where an audience is already listening. *Voice of the Diabetic* offers such an outlet. Make *your* voice heard. For advertising information contact:

**Voice of the Diabetic**
**Ed Bryant, Editor**
**811 Cherry Street, Suite 309**
**Columbia MO 65201**
**(314) 875-8911**


## Subscription/Donation Form

The ***Voice of the Diabetic*** is a quarterly magazine published by the Diabetics Division of the National Federation of the Blind (NFB) for anyone interested in diabetes, especially diabetics who are blind or losing vision. It is an outreach publication emphasizing good diabetes control, diet and independence.

Donations are gladly accepted and appreciated. Contributions are not only tax deductible but are needed to keep the ***Voice*** and the Diabetics Division moving forward to help people with all aspects of diabetes.

Members of the NFB Diabetics Division enjoy priority services and unique benefits such as a continuous free subscription to the ***Voice,*** automatic access to committees covering all aspects of diabetes, free counseling concerning all facets of blindness and diabetes as well as access to diabetics who have experienced complications.

The ***Voice*** is free to any interested person upon request. Each subscription costs the Diabetics Division approximately $20 per year. To help defray publication expenses, members are invited, and nonmembers are requested, to cover the subscription cost.

**To begin receiving the *Voice*, *please check one:***

[ ] I would like to become a member of the NFB Diabetics Division and receive the ***Voice of the Diabetic.*** (Members are entitled to special membership benefits.)

[ ] I would like to receive the ***Voice of the Diabetic*** as a nonmember. (Nonmembers are requested to pay the institutional rate of $20/one year; $35/two years; $50/three years.)

Send the ***Voice*** in (check one):

[ ] print [ ] cassette tape for the blind and physically handicapped (recorded at slower-than-standard speed of 15/16 IPS) [ ] both

Optionally check this box:

[ ] I would like to make (or add) a tax-deductible contribution of $ _____ to the Diabetics Division of NFB.

*Please print clearly*

Name _____

Address _____

City _____ State _____ Zip _____

Telephone ( _____ ) _____

Send this form or a facsimile to:
***Voice of the Diabetic,*** 811 Cherry St., Suite 309, Columbia, MO 65201

Please make all checks payable to:
**NATIONAL FEDERATION OF THE BLIND**